BLACK AGED IN NURSING HOMES: AN APPLICATION OF THE SHARED FUNCTION THESIS

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ABSTRACT

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FUNCTION THESIS

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This study had three main goals. The first was to describe the institutionalized Black aged in terms of their relevant demographic characteristics and reasons for admission. The second was to explore the relative importance of ethnic and cultural factors in service delivery to this population. The third was to examine the role which the Black family plays within the institutional setting as measured by patterns of visiting and task performance.

The application of the Shared Function Thesis to the situation of aged Blacks in nursing homes resulted in the formulation and testing of eight hypotheses. These hypotheses put forth possible explanations as to how the family and the nursing home work together as a Shared Function and how this cooperative relationship affects resident satisfaction with care and resident morale.

Data on these areas were obtained in structured interviews with nursing home administrators, residents, and family members. The sample was drawn from five selected voluntary nursing homes in New York City. A combination of random and purposive sampling resulted in the selection of 93 residents who were interviewed as part of the study between January and September 1978. Sixty-four of the 93 residents in the study sample

had family available. Twenty-seven of these family members were interviewed. In addition, data on resident physical and mental health status, as well as corroborative data on family involvement were collected in questionnaires completed by the nursing home staff.

Several major findings emerged in each area. Data on the demographic characteristics of this population were compared to existing norms for Black aged in the community. The institutionalized persons in the study sample were significantly older and there were many more widowed and never married persons. These findings would seem to indicate that lack of spouse or other familial supports in the face of advancing age and impairment is a major reason for admission to the nursing home. It was also found that availability of family was significantly related to sex of the older person. Black aged males in the study sample were less likely than aged females to have family available.

On the question of ethnic factors in service delivery, two major findings emerged. The nursing homes which serve a majority of Black residents and were therefore defined as "ethnic" were more likely than the non-ethnic nursing homes to include cultural components in routine activities. These components included the celebration of holidays important to Black aged, the regular provision of ethnic foods and the inclusion of Black music and art in social activities. The second finding was that consumer attitudes were related to the ethnic orientation of the host facility. This was especially true for issues of matching provider and consumer on the basis of ethnicity than for the inclusion of cultural components in routine activities for which there was ample

support from most residents and family members.

With reference to the third area, the role of the family within the nursing home, data were obtained on patterns of visiting and patterns of task performance by family members and friends. On both indicators of shared function, visiting and task performance, there was evidence that family continue to play a meaningful role in the lives of their aged members even after institutionalization. Findings indicate that friends also visit frequently. Resident and family reported levels of visiting were very high and were above established norms for all Blacks in nursing homes. The reported level of visiting was also significantly higher than that reported for a sample of predominantly white, middle-class institutionalized aged in a similar study in the same locale.

With respect to task performance by family and friends, the most commonly reported tasks performed were the provision of food treats, shopping and running errands, and the provision of clothing. Both the level of visiting and task performance were significantly related to resident and family satisfaction with care in a positive direction.

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CHAPTER I

INTRODUCTION

This study of Black elderly residents of nursing homes draws on three main research perspectives, all related to the situation in which this population finds itself. The first involves concerns of gerontology, and the needs of the aged population; the second concerns ethnicity, and the special situation of the Black aged; and the third perspective relates to the role of the family, and the shared function in caring for the frail elderly as between the primary group and the institution.

The decade of the 1970's has been a period of significant expansion for the field of gerontology. One aspect of this growth has been an increased attention to the concerns of minority aged. For aging and aged Blacks, in particular, there is an increasing amount of literature which has grown out of the research of several scholars in the field of social gerontology (Kent, 1971; Jackson, 1971; Cantor, 1973; Faulkner, 1976; Lopata, 1975; Wershow, 1976; Dancy, 1977 and Soldo and DaVita, 1978).

Most of this research has been focused on Black aged who reside in the community, either alone or in shared households. Predominant issues have been demography of the Black aged, health issues, economic security, employment, life satisfaction, and relationships with family.

One area, however, has been virtually ignored with the exception of one or two studies. This is the area of aged Blacks who reside in nursing homes or other long-term care facilities.

According to the most recent statistics available from the National Nursing Home Survey (1973-74),[1] Blacks represent 4.6 percent of the 1,075,800 nursing home residents in the United States. There are, then, an estimated 49,300 Blacks in nursing homes and most of them are aged.

Very little is known about this population. In most research studies on the institutionalized aged, Blacks are not included in the sample. Where they are, key variables have been rarely disaggregated by aged and race simultaneously. It has, therefore, been very difficult to learn more about this group.

This study was undertaken to help fill this gap in knowledge. Using a sample of Black aged residents from five selected voluntary nursing homes in New York City, the study will report on their demographic characteristics, reasons for admission, special needs with respect to institutional long-term care, and preferences for patterns of care. In addition, the study will test certain hypotheses regarding the family's role within the institutional setting.

Another feature of the 1970's has been the increased attention to aspects of cultural pluralism. Ethnicity has emerged as a key variable in politics, social relations, education and social welfare. In the social service sector, ethnic and cultural factors have been viewed

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[1] Aurora Zappolo, Characteristics, Social Contacts and Activities of Nursing Home Residents, United States 1973-74 National Nursing Home Survey (Washington, D.C.: Department of Health, Education and Welfare, May 1977).

less as components of "problem definition" and more as important criteria to be considered in the design and delivery of social services to minority groups. There has been a substantial increase in research and literature on "culturally relevant" service delivery. Much of this has grown out of the concerns of minority professionals in the social service field.

One area which has been the focus of ethnic research is the field of child welfare. Within child welfare issues of equal access, appropriate entitlements, and attention to prevalent cultural patterns in designing programs for children have come under scrutiny. One major study in this area, "Ethnic Factors in Child Welfare,"[1] undertaken at the Columbia University School of Social Work, systematically examined each of these factors across several service settings including children in institutions. One of the issues most clearly identified in this research was the importance of cultural content in designing programs. Operationally, this referred to the inclusion of ethnic holidays, arts, music, history, folklore, and foods as integral program components. There are many implications of this for maintenance of cultural continuity for children in congregate care facilities. If cultural continuity is deemed important for young children, might not the same case be made for aged persons in congregate care facilities? In fact, perhaps an even stronger case could be made given the well documented attachment of the elderly to traditional cultural patterns.

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[1] Shirley Jenkins and Barbara Morrison, "Ethnicity and Service Delivery," American Journal of Orthopsychiatry, 48: 1 (January 1978), pp. 160-165; Shirley Jenkins, "The Ethnic Agency Defined" (paper presented at the American Orthopsychiatric Conference, Washington, D.C., April 1979).

With respect to the importance of ethnic factors in service delivery, the second purpose of this study can be identified as a desire to ascertain how nursing homes are including cultural components in service delivery to their Black aged clients, if at all. Because consumer opinion and preference are part of any service delivery system, it seemed necessary to assess the relative importance of ethnic factors to the Black aged residents. No research in this area has been identified, despite a substantial search. The one study undertaken recently on minorities in long-term care reported on consumer preferences as they were reflected in the available literature.[1] Actual consumers of service were not interviewed as part of that study. It was felt that one important contribution of the present research would be to identify preferences for patterns of care as they were actually expressed by aged Blacks in nursing homes, and to note if and how their stated preferences differed from opinions of published professionals.

A further theme which emerged in the "Ethnic Factors in Child Welfare" study was the issue of "matching" vs. "mixing" of worker and client on the basis of ethnicity or language. The position of most published minority professionals in the child welfare field was that the interests of minority children were most likely to be protected where administrative and front-line staff were of the same ethnic group as the children served. In some sectors there was a definite push for the creation of a separate child welfare system designed by the ethnic

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[1]Forward Management Associates, Inc., "A Study of the Special Needs of Racial/Ethnic Minorities and Provider Attitudes in Long-Term Care Facilities: Educational Implications," Final Report, Department of Health, Education and Welfare, Division of Long-Term Care, January 31, 1977 (unpublished).

group to meet its own child care needs.[1]

The obvious question is for what other service systems might this be an issue? The ethnic auspices of so many nursing homes, particularly the voluntary facilities, would suggest that such a view has not only been widely held, but operationalized in actual service delivery. A third purpose of this study was to ascertain resident opinion on the relative importance of "matching" vs. "mixing" on the basis of ethnicity. In addition, there was an interest in knowing how racial homogeneity of staff and resident population affected other variables such as satisfaction with service and resident morale.

Another issue which emerged in the "Ethnic Factors in Child Welfare" study was raised by some of the minority professionals in non-traditional child care settings. This was the importance of the natural and biological family and maintenance of its role with the child. One Black foster care agency, for example, prided itself on its work with natural families. Every effort was reportedly made to include natural, as well as foster families in agency programs and activities. This agency clearly did not see itself as devoted to "child saving." The importance of the family in ethnic sub-cultures has been widely documented in the sociological literature. Blacks have been no exception to this pattern (Billingsley, 1968; Scanzoni, 1973; Stack, 1972; and Staples, 1972).

The importance of the family to the aged has also been well documented (Burgess, 1975; Leichter and Mitchell, 1967; Shanas and

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[1] Andrew Billingsley and Jeanne M. Giovannoni, Children of the Storm: Black Children and American Child Welfare (New York: Harcourt, Brace and Javanovich, 1972).

Streib, 1965, and Shanas and Townsend, 1968). A review of the gerontological literature has revealed several studies on intergenerational relationships within and across various ethnic groups. Some of these have provided data on such patterns in Black families (Cantor, 1975; Dancy, 1977, Feagin, 1968, Jackson, 1972; and Wylie, 1971). Each of these studies documents the importance of family to the maintenance of the Black aged in the community. There is no study, however, which examines the role of the Black family within the long-term care facility. More specifically, there is no research on whether or not community-based patterns of helping are carried over to the institutional setting. Studies have documented the close relationships between most Black aged and their relatives, but there are apparently no data on whether or not such relationships are maintained once institutionalization of the aged member has occurred.

Data from studies on predominantly white samples do suggest that families remain involved even after institutionalization of the aged member (Dobrof, 1976 and York and Calsyn, 1977). Dobrof, for example, found that presence of family within the institutional setting had many implications for the quality of care which residents received.[1] Families also provided a system through which the most idiosyncratic needs of the resident could be met. Her study findings have run counter to the stereotype that nursing homes and other long-term care facilities are populated by aged persons who have been dumped by selfish and uncaring children. In addition, her findings have shown that

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[1] Rose Dobrof, "Care of the Aged: A Shared Function" (unpublished DSW dissertation, Columbia University School of Social Work, May 1976).

nursing homes and families develop ways to care for the aged person as a "shared function," each contributing to physical and emotional well-being in their own unique way. Dobrof's sample was predominantly white and Jewish, with some Blacks and Hispanics also included. Although a small proportion of her sample was comprised of racial minorities, she noted some differences between these residents and the others on some key study variables. Her final recommendations included the suggestion that her research be replicated with samples of minority aged in long-term care facilities. This study is, in part, such a replication. It also extends beyond the Dobrof research by placing more importance on the role of ethnicity as a determinant of shared function. Specifically, it questioned whether the ethnic orientation of the nursing home makes a difference in terms of (1) availability of family to play a role; (2) family-facility patterns of cooperation; and (3) implications of these factors for resident satisfaction with care and resident morale.

In summary, the study has three major purposes: (1) a description of Black institutionalized aged in terms of their relevant demographic characteristics and reasons for admission; (2) an exploration of the relative importance of ethnic factors in service delivery to this population; and (3) an assessment of the importance of familial factors to their care and well-being.

The major research questions which have guided this inquiry may be stated as follows:

1. What are the salient demographic characteristics of aged Blacks in long-term care facilities in New York City? How do these compare to available data on white aged in institutional long-term care?

2. What are the major reasons for admission of Black aged to nursing homes? What is the nature of decision-making around the admission?

3. Are long-term care services being delivered in ways which are culturally congruent with the predominant cultural patterns among Black aged? If so, what cultural components are included in service delivery?

4. How does the ethnic orientation of the nursing home affect the nature of service delivery?

5. How important are ethnic factors to Black aged residents and their families with respect to dietary services, social activities, staff composition and administration of the nursing homes?

6. How available are families to the Black aged in institutions?

7. If available, how do Black families work with the nursing homes to assure the best care possible for their aged members?

8. Does Black family involvement manifest itself as a function of outreach to staff, attendance at special programs, level of visiting, and task performance as has been shown to be the case for many white families with institutionalized members? What are the differences between these two groups on patterns of family involvement?

9. How do these ethnic, cultural and familial factors affect resident satisfaction with service?

10. How do these ethnic, cultural and familial factors affect overall resident morale?

This document is organized into eight chapters. Chapter II focuses on the study population and what is known about it from the professional literature. Chapter III presents the conceptual framework of the study including the research hypotheses and operational definitions of study variables. Methodology, sampling and data collection instruments are discussed in Chapter IV. Chapter V presents a detailed description of the resident respondents and the family member respondents. Chapter VI examines the role of ethnic factors in long-term care by taking a closer look at the nursing home experience for aged Blacks. Included in this chapter will be data on the decision-making process prior to admission, resident and family feelings about

the decision to enter the nursing home, and attitudes related to the importance of cultural factors in service delivery. The Shared Function Thesis and its applicability to Blacks will be addressed in Chapter VII, where data on the Black family's role within the nursing home will be presented and study hypotheses will be tested. Finally, a summary of major study findings with relevant practice and policy recommendations will be presented in Chapter VIII.

CHAPTER II

THE AGED BLACK POPULATION AND ITS PROBLEMS

There is a sparse literature on Black aged who reside in institutional settings.[1] Most of the studies available survey Black elderly who reside in the community. These studies, however, provide background information and a contextual framework for the present study in several ways. In the first place, they give an overview of the demographic characteristics of the Black aged population, thereby indicating the presence of social and health factors which place this population "at risk" of institutionalization. Secondly, they provide data on patterns of interaction and reciprocol aid between the Black elderly and their families which may carry over into other situational contexts such as the nursing home. Finally, they present data on the role which the family plays in the care of the institutionalized aged of other ethnic groups, thereby providing comparative data against which patterns particular to Black families can be assessed. The few studies which are available on minorities in long-term care are also reviewed.

This material is presented in three sections. First, factors

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[1] A review of ten years of gerontological literature was undertaken for the years 1967-1977 inclusive. With the aid of two computer search services: the Aging Research Information System (A.R.I.S.) and MEDLINE, published articles and papers on the Black aged were identified. In addition, several important but unpublished papers were made available from the authors upon request.

which place Blacks at risk of institutionalization are examined, with appropriate attention to countervailing cultural patterns and attitudes which mitigate risk. With respect to the latter, particular attention will be paid to the family relationships of aged Blacks, attitudes of filial responsibility and patterns of reciprocal aid within Black families.

Secondly, available data on Black aged in nursing homes will be presented. Findings from current research which relate to the referral and admission process will be presented, as well as data on culturally relevant service delivery to minorities in long-term care.

Finally, data from studies on the role of the family within the institutional setting will be examined. These findings establish a comparative framework against which the data from this study can be assessed.

1. Demographic Characteristics of the Black Aged: Identification of Risk Factors

Research on the institutionalized aged population has shown the consistent emergence of three key variables associated with admission to long-term care facilities (Brody, 1970; Townsend, 1968; and Zappolo, 1977). The first is advanced age: more than half of the institutionalized population is over 80 years and the chance of becoming institutionalized increases with age. The second is health: 80 percent of the institutionalized aged have serious health problems and impaired mental functioning. The third factor is family composition: there are three times as many widowed persons in long-term care facilities as there are married and single individuals. In addition, many more

institutionalized aged have only one adult child as compared to aged still in the community.

If these are the factors which place an aged individual "at risk" of institutionalization, it is important to look at the Black aged population in terms of these key variables as a means of assessing risk.

According to the 1970 census, Blacks comprise eight percent of the 20 million persons aged 65 and over in the United States. Thus there are 1,566,000 elderly Blacks in the United States, a 34 percent increase from the 1,168,000 reported in the 1960 census.[1] The increase for the total U.S. aged population for the same period was 21 percent.[2]

With respect to the study site, in 1974 there were 122,317 nonwhite persons aged 65 and over in New York City (excluding Puerto Ricans and other Hispanics). It is estimated that 75.5 percent of these, or approximately 92,396 are aged Blacks.[3]

It is difficult to specify the exact number of Black nursing home residents either on a national basis or for New York City. Statistics on this population are rarely disaggregated by race or ethnicity. Consequently, the best available estimates are used here in describing the study population. Based on the 1973-74 National Nursing Home

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[1] Robert Hill, "A Profile of the Black Aged," Occasional Papers in Gerontology No. 10 (Detroit: Institute of Gerontology, Wayne State University, 1974), p. 35.

[2] Louis Lowy. Social Work With the Aging: The Challenge and Promise of the Later Years. (New York: Harper and Row Publishers, 1978), p. 23.

[3] Barbara Dickson Hanrieder, "Demographics of New York City Elderly as of 1976," Facts for Action Series (New York City: Department for the Aging, November 1978), p. 3.

Survey, Blacks comprise 4.6 percent of the 1,075,800 persons in nursing homes in 1974. Of these, 40,700 or 83 percent were aged 65 and over. It can thus be estimated that aged Blacks in nursing homes comprise about four percent of the national nursing home population.[1]

Using the four percent estimate as applied to the Black aged population in New York City, there would be approximately 3,695 Blacks aged 65 and over in nursing homes. This group constitutes the population of this study.

Risk Factors: Age, Health and Marital Status

Blacks as a population are aging and the female population is aging faster than the male. Based on his analysis of 1970 census data, Hill reported that the number of Black elderly males aged 65 and over increased 25 percent from the 1960 to the 1970 census. The increase for Black elderly females was 41 percent from 1960 to 1970.[2]

The many improvements in health, sanitation and nutrition that have occurred during this century have added proportionately more years to the life expectancy of Blacks than to whites. The average life expectancy for Blacks has doubled since 1900, while the increase for whites has been only half as great.[3]

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[1] Aurora Zappolo, Characteristics, Social Contacts, and Activities of Nursing Home Residents, United States, 1973-74 National Nursing Home Survey, Department of Health, Education and Welfare Publication No. (HRA) 77-1778, May 1977, Table A, p. 3, and Table 3, p. 22.

[2] Hill, op. cit., p. 35.

[3] U.S. Department of Health, Education and Welfare, Administration on Aging, Statistical Memo No. 31: Estimates of the Size and Characteristics of the Older Population in 1974 and Projections to the Year 2,000 (May 1975), p. 3.

It would appear, then, that longevity for Blacks is on the increase--a fact which might be expected to increase the risk of institutionalization for Blacks in the future.

With respect to health status, it would appear that Blacks are at greater risk of institutionalization than whites. In their secondary analysis of data on 200 elderly Blacks from the study sample in "The Myth and Reality of Aging in America" (Louis Harris and Associates, 1974), Jackson and Woods found that older Blacks were significantly higher than other groups in feeling that their health status was worse than expected. Poor health was cited as a serious problem by 70 percent of the Black respondents, as compared to 48 percent of white aged. In addition, 47 percent of the Black aged as compared to 21 percent of the white aged cited poor medical care as a major problem for the elderly.[1] Black aged were found more likely to be suffering from chronic and disabling health problems, and least likely to visit a doctor. The researchers attribute this to the high cost of medical care and the scarcity of medical facilities in areas where aged Blacks are most likely to live.

There is growing medical evidence that Blacks are older in body age when compared to whites of the same chronological age. Morgan's research has shown that Black males of 30 calendar years on have an older body age than their white counterparts. The biggest jump in body age is between 21 and 30, after which Blacks hold a five-year body age differential until age 60 when the differential increases much more

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[1] Maurice Jackson and James L. Wood, The Black Aged: Aging in America, No. 5 (National Council on Aging, 1976), p. 28.

rapidly.[1]

Other evidence of poor health among the Black aged can be found in reasons for early retirement from the labor force. In his study of 100 aged Blacks in Detroit, Henderson found that 80 percent of the men in his sample and 75 percent of the women had retired from full-time employment before reaching the age of 65. Sixty-four percent of the men and 84 percent of the women gave poor health as the reason for early retirement.[2]

Data on aged Blacks in New York City support all of these findings. The findings of Cantor's study of 1,552 New York Inner City Elderly indicate that elderly in the city have poorer health than elderly in other parts of the State, and significantly poorer health than the national norms. Among the inner city elderly, the 580 Black elderly respondents had the worst self-reported health status, with 72 percent reporting at least one major health problem. Arthritis, rheumatism, and hypertension were the problems most frequently cited.[3] It was also found that, for 25 percent of the Black inner city elderly, functional incapacity was such that they were unable to go outdoors, use stairs, bathe or dress themselves without some degree of assistance.[4] Thus if

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[1]Robert F. Morgan, "The Adult Growth Examination: Preliminary Comparisons of Physical Age in Adults by Sex and Race," Perceptual Motor Skills, 27: 1068, p. 598.

[2]George Henderson, "Negro Recipients of Old Age Assistance Results of Discrimination," Social Casework, 46 (April 1969), p. 210.

[3]Marjorie Cantor, "Health of the Inner City Elderly," (paper presented at the 27th Annual Meeting of the Gerontological Society, Portland, Oregon, October 1974), pp. 3-4.

[4]New York City Department for the Aging, "Selected Findings on the Black Elderly," in The Elderly in the Inner City (monograph prepared for the New York State Seminar on the Black Aged, New York, June 27-28, 1974), p. 6.

poor health increases the risk of institutionalization, Blacks should be more at risk than whites.

On variables of marital status and family composition, a mixed picture emerges with regard to risk. Although Blacks are as likely as whites to have been married at some point in their lives, they are less likely to stay married. Rubenstein noted that one out of every five elderly Black women are living apart from their husbands. In addition, Black women are at much greater risk of early widowhood when the marriage does survive, because of the lower life expectancy for Black males (i.e., 61 years). These patterns are especially true of Black aged in urban areas.[1] New York City's aged Black women, for example, were found by Cantor to have the second highest rate of marriage, but only 29 percent were still married at the time of the interview. When compared to white and Hispanic aged, Blacks had the highest rate of divorce and separation.[2] Thus, if lack of spouse is a risk ractor, Black aged women, in particular, are significantly at risk because of early widowhood, and high rates of divorce and separation. Counteracting many of the risk factors is the relative advantage Blacks appear to have with respect to availability of children, as several studies show. References to the "extended family" among Blacks are frequently cited in the sociological literature. However, current research on

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[1] Daniel I. Rubenstein, "An Examination of Social Participation Found Among a National Sample of the Black and White Elderly," Aging and Human Development, 2 (1971), pp. 172-173.

[2] Marjorie Cantor, "The Elderly in the Inner City: Some Implications of the Effects of Culture on Life Styles" (paper presented at the Institute on Gerontology and Graduate Education for Social Work, New York City, Fordham University at Lincoln Center, March 20, 1973), pp. 4-5.

Black families suggests that the extended family, at least in its traditional form of the multi-generational household, is much less characteristic of Black families than it once was (Billingsley, 1968). Extended family structure, where it does exist, appears to be related to socioeconomic status, geography and sex of the aged parent.

In a study of aged Blacks in Durham, North Carolina, Jackson found that all of the aged Black males and 63 percent of the aged Black females in her sample lived in their own homes at the time of the interview. However, 46 percent of the men and 42 percent of the women either lived with or had at least one adult child living with them at the time of the survey.[1] There appears to be a smaller incidence of household sharing among Black aged in Northern urban areas, although the likelihood of sharing a household is greater than it is for white aged. In New York City, Cantor found that 89 percent of the Black aged maintained their own homes but only 34 percent lived alone in those homes. Twenty-six percent lived with relatives and 11 percent lived with other non-related individuals.[2]

These patterns in the Cantor study were related to sex in that more Black aged women than men lived in shared households; to social class since all of the Black aged women living in shared households came from the lower socioeconomic group; and to length of residency since the vast majority in shared households were recent arrivals,

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[1] Jacquelyne Jackson, "Sex and Social Class Variations in Black Aged Parent-Adult Child Relationships," Aging and Human Development, 2 (1971), p. 97.

[2] Cantor, op. cit., p. 10.

usually from the Southern states. Thus the sharing of household was a way to pool economic resources. Caution should be exercised in assuming that such living arrangements were the pattern of preference. There were many more working and middle-class Black aged women among those who were married and living with a spouse and those who never married and/or lived alone.

With respect to availability of children, Cantor found that 60 percent of the Black aged women in New York City had one or more living children. Women living in extended or augmented households were the most likely to have a living child (75 percent) compared to married women (53 percent) and living alone (43 percent). Compared to whites, Black aged had more family available to them, but less when compared to Hispanic aged.[1]

What these data would suggest is that availability among aged Blacks of adult children who could provide assistance in times of illness or even continuing care in cases of chronic disability is one factor which lessens the risk of institutionalization. To the extent that availability of children is related to socioeconomic status and marital status, it might be expected that a higher percentage of working and middle-class Black elderly and those who are never married and/or without children are especially vulnerable.

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[1]Marjorie Cantor and Karen Rosenthal, "Social and Family Relationships of Black Aged Women in New York City" (paper presented at the 28th Annual Meeting of the Gerontological Society, Louisville, Kentucky, October 1975), p. 13.

Family Relationships of Black Aged and Filial Responsibility

As the demographic data show, most Black elderly have at least one adult child. Most of these children were found to live close to the parent and in some cases in the same household. But proximity alone is not necessarily a valid indicator of contact or the quality of the relationship. In her probability sample of aged in New York City, Cantor reported that 57 percent of the 376 Black aged women saw at least one of their children daily. An additional 20 percent saw at least one child weekly, with another 14 percent seeing at least one child on a monthly basis.[1] Thus, 90 percent of the aged Black women in New York City who had children, had some degree of regular contact with them. When asked to evaluate the affective quality of the relationship, 66 percent of these women rated their relationship with adult children as "very close," 17 percent said "fairly close," and 16 percent said, "not too close."[2]

Thus for the site of this study, the data on Black aged women would suggest that relationships between these women and their families are quite good. No such analysis was done for Black males because of their smaller representation in the study sample.

In their secondary analysis of data from the National Council on Aging study, "The Myth and Reality of Aging," Jackson and Wood compare patterns of intergenerational assistance in Black and white families. The following listings from their report present their findings, which

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[1] Cantor and Rosenthal, op. cit., pp. 15-16.

[2] Ibid., pp. 12-13.

were based on a multi-stage probability sample of 4,254 older persons, including 200 Blacks aged 65 and older.[1]

Patterns of Help from Children and Grandchildren to Elderly Parents/Grandparents by Race

Nature of Task	Blacks (percent)	Whites (percent)
Giving gifts	86	96
Care when ill	78	74
Errands	71	69
Take you places	61	57
Fix around house	57	55
Give money	48	21
Financial advice	40	23
General problem advice	33	23
Advice on running home	27	13
Advice on jobs	17	13

Patterns of Help from Elderly Parents/Grandparents to Children and Grandchildren by Race

Nature of Task	Blacks (percent)	Whites (percent)
Giving gifts	75	91
Care when ill	73	68
Advice on problems	63	37
Care of grandchildren	45	54
Advice on childrearing	54	20
Financial advice	41	45
Advice on running home	41	19
Errands/shopping	33	34
Advice on jobs	32	18
Fix around house	31	26
Taking grandchildren into the home	26	15

[1] Maurice Jackson and James L. Wood, The Black Aged: Aging in America, No. 5 (National Council on Aging, 1976), pp. 35-37.

What is shown in the data is that Black elderly parents in the study receive more help from their children and grandchildren than elderly whites do in every category of help except gift giving. They are particularly more likely to receive help in the form of being taken places; given financial aid and financial advice and advice on running the home. As for help flowing in the opposite direction, elderly Black parents are less likely than white parents to give gifts; take care of grandchildren in their parent's home; and slightly less likely to give their adult children and grandchildren financial advice. In all other categories, Black elderly parents are involved in more helping relationships with their offspring, particularly in caring for an ill child; giving advice on childrearing; giving advice on running the home; giving advice on jobs; and taking a grandchild into the home.

Cantor also found patterns of mutual assistance in her random sample of New York City Black elderly. She reports that, "The amount and extent of mutual instrumental and affective assistance reported by aged mothers and their children is indeed impressive and belies the stereotype of the Black family as dysfunctional or disintegrating."[1] Eighty-six percent of Cantor's sample of Black elderly women and their children were involved in helping patterns.

The patterns of assistance between aged Blacks and their families compared to other ethnic groups suggest that economic differences account for different patterns of aid. There is also reference to the "expectation" of assistance in the Hispanic culture. Many

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[1] Cantor and Rosenthal, op. cit., p. 18.

[2] Ibid., pp. 20-21.

sociologists feel that the "expectation" of aid is also very much a part of Black culture, as shown in attitudes toward filial responsibility.

There is in our society as a whole considerable stigma attached to the inability of the family to care for its aged members.[1] Institutionalization of an aged member is usually a very painful experience and occurs most often when all other alternatives have failed.

> . . . the social expectation is that a middle-aged or aging couple introduce an old parent into their home sometimes after a half-century of separate living and often in crowded quarters of an urbanized industrial society. Such expectations come into sharp focus with regard to families of the institutionalized elderly. A long inventory in relation to all kinds of institutions has shown when such care is requested, it is most often the last resort (e.g., Lowenthal, 1964; Friedson and Dick, 1963; and Brody, 1969).[2]

If such a pattern characterizes the larger society, it is commonly held that such a pattern is even more true for Blacks. In his paper which attempts to trace African survivals in Black American attitudes toward the aged, Wylie wrote that:

> It is generally accepted that Black Americans are more inclined than whites to include the elderly in the family structure and to regard the elderly with respect, if not veneration . . . the strength of cultural traditions of the extended family and clan, the regard for life, the reverence of old age and ancestors, were not, contrary to some opinions, dissolved or broken by slavery.[3]

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[1] Theodore Rosen, "The Significance of the Family to the Resident's Adjustment in a Home for the Aged," Social Casework (May 1962), p. 241.

[2] Elaine Brody, "The Etiquette of Filial Behavior," Aging and Human Development, 1 (February 1970), p. 89.

[3] Floyd M. Wylie, "Attitudes Toward Aging and the Aged Among Black Americans: Some Historical Perspectives," Aging and Human Development, 2 (1971), p. 66.

An example of this attitude is probably best illustrated by the remarks of the late Fannie Lou Hammer, a child of sharecroppers who went on to become a civil rights spokeswoman. In a "Memorial to Fannie Lou Hammer" which appeared in the Golden Page, the publication of the National Caucus on the Black Aged, she is quoted as having said:

> There are many things I see that I worry about . . . I see Black people putting their people in homes. They have something here called "care in" where people take their own parents and carry them to these places and put them there because they are old, you know. I think it's a disgrace. Are we losing our humanity? My mother was 98 when she died on the 8th of February in 1961. There was no way on earth she would ever leave my house, to be put off somewhere on somebody that didn't even know her and didn't care.[1]

Although the literature search has not shown systematic study of the attitudes on placement of elderly, there are some clinical impressions that the struggle to place an aged relative is particularly hard for Black families because of the strong sense of filial responsibility. The suggestion has been made that social workers in hospitals and social service agencies need to be particularly aware of this struggle.[2]

One study undertaken by Jackson found that Blacks were more likely than whites to take care of ill and frail aged members in the home. Of this pattern she notes:

> . . . Although data were not available by socio-economic status, an inverse relationship probably operates between income and home care or there may be a curvilinear relationship. There is, in the absence of spouse, likelihood of institutionalization when need increases with

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[1] National Center on the Black Aged, "Memorial to Fannie Lou Hammer," Golden Page, 1 (April 1977), pp. 12-13.

[2] Joseph Dancy, Jr., The Black Elderly: A Manual for Practitioners (Ann Arbor, Michigan: Institute of Gerontology, 1977), pp. 20-21.

> increasing socio-economic status of the aged person (or his or her adult children) except in the very highest income levels. Among blacks, greater institutionalization among those with middle socio-economic ranges may be a function of fewer available children, grandchildren and other relatives, greater geographic distance between an aged person and his children, and full-time employment of both spouses in most black families in the labor force.[1]

In establishing the need for institutional long-term care among aged Blacks, a range of factors must be considered. Demographic variables such as age, sex, marital status and health status appear to increase the risk, but there are countervailing cultural factors such as strongly held attitudes of filial responsibility. A third set of factors, not examined in this research are related to issues of access and discrimination in referral and admission policies. To fully understand patterns of need and service utilization, all of these factors need to be considered.

2. Blacks in Institutional Long-Term Care

Each of the few available articles and papers on Blacks in long-term care facilities deals with the issue of access. Separation by race is a persistent phenomenon, except in established public facilities. A recent survey on Minorities in Long-Term Care and Provider Attitudes, reports that nursing homes throughout the country fall into two categories: those which are predominantly white and serve none or a small percentage of non-white clients, and those which are

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[1] Jacquelyne Jackson, "Aged Negroes: Their Cultural Departures from Statistical Stereotypes and Rural-Urban Differences," The Gerontologist, 10 (Summer 1970), p. 142.

predominantly non-white.[1]

In her article, "Life After 65," which appeared in Black Enterprise, Hicks characterized nursing homes as "the most discriminatory institutions in the country. To the extent that nursing homes are affiliated with church groups, the same can be said for them. The few black nursing homes in operation met a setback in 1974 when stringent enforcement of Federal safety codes made many close their doors."[2] Several gerontologists share this view. Jackson has noted that factors other than chance affect the underrepresentation of Blacks in nursing homes. Aged Blacks are least numerous in proprietary nursing homes, and Jackson attributes this to "racism in many such white-owned homes and the paucity of black-owned proprietary nursing and personal care homes."[3] Brody suggested that the underrepresentation of Blacks may reflect the quality of existing service and their availability to groups like the poor and nonwhite. Implementation and expansion of coverage by Title 18 and 19 /Medicare and Medicaid/ should make institutional long-term care more available, according to Brody.[4] The degree to which age-related entitlements like Medicare and Social Security can make needed care more accessible is questionable for many aged Blacks, particularly Black aged males whose current life expectancy is 61.1

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[1] Forward Management Associates, Inc., "A Study of the Special Needs of Racial/Ethnic Minorities and Provider Attitudes in Long-Term Care Facilities: Educational Implications," op. cit., p. II-8.

[2] Nancy Hicks, "Life After 65," Black Enterprise, 7 (May 1977), p. 21.

[3] Jacquelyne Jackson, "Help Me Somebody: I's an Old Black Standing in Need of Institutionalization," Psychiatric Opinion, 10 (1973), p. 12.

[4] Elaine Brody, "The Etiquette of Filial Behavior," Aging and Human Development, 1 (February, 1970), p. 90.

years . . . four years before they would qualify for Medicare or Social Security benefits.[1]

There is one other hypothesis offered for the reported underrepresentation of Blacks in institutional care facilities: erroneous estimates of the actual numbers served. As was noted previously, the generally accepted estimate is four percent. One researcher has challenged this figure which is based primarily on census data. While undertaking a study of aged Blacks and whites in nursing homes in Birmingham, Alabama (and several rural proximate counties), Wershow discovered that the number of institutionalized aged Blacks for the site of his study had been grossly underestimated by the 1970 census. In reviewing statistical data from the volume on Persons in Institutions and Other Group Quarters (U.S. Census, 1973), he found that only 36 Black nursing home patients were identified: all male and all in state and federal institutions. Yet Wershow's pilot study uncovered 197 Black nursing home patients, 76 males and 121 females, residing in five Black-owned nursing homes. All settings were skilled care facilities, certified by Medicare and Medicaid and licensed by the State Department of Health.[2] Underreporting was also found for Florida, Georgia, and Washington, D.C. The Census Bureau was made aware of this discrepancy by Wershow and his associates, but at the printing of the article, no reply or explanation had been received. He concludes that there is a need for better statistics on nursing home patients

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[1] Jacquelyne Jackson, "The Backlands of Gerontology," Aging and Human Development, 2: 3 (1971), pp. 156-171.

[2] Harold J. Wershow, "The Four Percent Fallacy: Some Further Evidence and Policy Implications," Gerontologist, 16 (February 1976), pp. 52-55.

disaggregated simultaneously by race and sex.

A recent study by Forward Management Associates provided data on reasons for admission and the referral process for Black aged in nursing homes. Most Black aged were admitted for reasons of poor physical health. This finding was not unexpected and follows the pattern for most admissions to nursing homes. The researchers stated that "despite efforts by some individuals to keep their loved ones within the accustomed environment, there often comes a time when long-term care becomes a necessary and logical alternative. Deteriorating physical and psychosocial conditions and changes in the family situation were the most commonly given reasons for need for institutional care . . ."[1]

With respect to the decision-making process, the role of hospital staff was a key factor. Over 80 percent of referrals were made by hospital medical or social service staff. In relation to referrals, concern was expressed by facility administrators that (1) hospital staff often referred non-white aged to white facilities because these were perceived to be of better quality, and (2) not enough information was being disseminated in minority communities with respect to location of facilities and the services offered. There was the opinion that negative stereotypes of nursing homes were prevalent among minorities, one reason why this service was not often explored as an alternative source of care.[2]

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[1] Forward Management Associates, op. cit., p. II-2.

[2] Ibid., p. II-6 - II-7.

Ethnic Factors in Long-Term Care
Service Delivery to Black Aged

Interviews with administrators in one study reported that "staffing patterns and racial composition of staff vis-a-vis the resident population were found overwhelmingly to be viewed as having some effect on the well-being of minority residents. Racial/ethnic minority residents were said to relate more favorably to staff members of their own racial and ethnic backgrounds."[1] If this is so, one would expect that residents in facilities which are staffed by members of their own group would have a higher level of well-being, although no empirical evidence was given to support or refute this hypothesis.

In addition to direct care staff, respondents in that survey also stressed the importance of minority representation on the Board of Directors. Since the Board's decisions set policies which ultimately have service implications for residents, it was felt that ethnic representation on the Board would better assure that the special needs of minority residents would be addressed.[2] Support for this view was expressed by facility administrators and staff across all four ethnic groups included in the study sample.

For each of the ethnic groups, the study identified particular cultural components which sould be included in service delivery. The major areas addressed were: (1) ethnic foods, (2) social activities, (3) grooming needs, and (4) language if the group was non-English speaking. Administrators reported that most minority residents showed

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[1] Forward Management Associates, op. cit., p. III-18.

[2] Ibid., p. III-8.

a distinct preference for their own ethnic foods, and this was the case in four of the five facilities visited in New York. With respect to aged Blacks, it was reported that "Blacks . . . were generally described as expressing a distinct preference for what is commonly referred to as 'soul food.' Soul food includes foodstuffs such as collard greens, cornbread, black-eyed peas, ham hocks, and smothered pork chops to name a few."[1] When these foods were not provided to Black residents, the researchers requested an explanation for not doing so. The usual response was that "culturally or ethnically relevant meals . . . were low in nutrient values."[2]

With regard to social or recreational activities, three issues were raised for Black residents. First, according to staff most Black residents indicated a preference for outdoor activities, such as walks and picnics.[3] Secondly, religion to the Black aged was considered to be important in planning social activities. "In recognition of the importance of religion in the lives of elderly Blacks, regular gospel meetings or prayer meetings are held. This type of activity was conducted several times per week and was extremely well received by the residents."[4]

A third point that was made was that aged Blacks have often not developed leisure type activities. Their employment situations have been such that hard work and long hours left them little time for

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[1] Ibid., pp. II-35 - II-36.

[2] Ibid.

[3] Ibid., p. II-33.

[4] Ibid.

developing hobbies or such activities. Staff members interviewed reported that Black residents preferred work-type activities. "In fact, many did request to assist with minor chores around the institution as a means of recreation and relaxation."[1]

For some Black aged residents grooming was a problem, particularly in white facilities where staff were not familiar with grooming techniques appropriate to the care of Black skin and hair. For example, Black hair is very dry and especially fragile when wet. Shampooing, conditioning and oiling, as well as braiding and styling require knowledge of Black hair types. Even when beauty parlors were available, many of the operators did not know how to care for the Black female resident's hair.[2]

As the review of these findings indicate, there are several well-defined issues around cultural relevance in long-term care. All providers, however, were not convinced of the importance of attention to these ethnic factors. In concluding their discussion of cultural relevance, the researchers state that:

> It is interesting to note that approximately twenty-five percent of the LTC administrative personnel interviewed by F.M.A., Inc. failed to acknowledge the significance of cultural factors with respect to delivery of service to racial/ethnic minorities. Those who were cognizant stated that they lacked the time and resources to address these issues and educate employees by way of their own in-house training programs.[3]

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[1] Ibid.

[2] Ibid., p. II-

[3] Ibid., p. II-19.

3. Shared Function: A Role for the Family Within the Institution

> The importance of "family" for the child has been universally accepted. The need of the aged for "family" is no less vital. The lack of family for the infant and aged alike, can be a major deprivation.[1]

References to the family and the importance of the family among Blacks have been made at several points in this review of the literature. There is ample evidence from recent studies in social gerontology to support the importance of family to aged Blacks (Cantor, 1973; Dancy, 1977; Feagin, 1968; Heisel, 1973; Jackson, 1972; Kent, 1971; and Lopata, 1975).

All of these studies have focused on Black aged who still reside in the community. One question is whether or not such relationships are maintained once institutionalization of an aged member has occurred. The literature search has not revealed any research in this area which is specific to Blacks. But there are data from studies on white aged in institutions which provide evidence of a continuing role for families within the institutional setting.

In describing his work with institutionalized aged, Rosen noted that:

> Whatever its services and resources, a home for the aged cannot provide the resident with that special source of security and support that can be supplied only through sound family relationships and understanding relatives. The aid of the family must be enlisted if the home is to increase the comfort of the resident, minimize social friction, and restore his productivity. At the same time, intolerable burdens of

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[1] Elaine Brody and Geraldine Sparks, "Institutionalization of the Aged: A Family Crisis," Family Process, 5 (March 1966), p. 77.

> responsibility must not be imposed upon any one of the family members.[1]

In a study of 250 case records selected at random from the files of a geriatric hospital in Ohio, Lissitz found that families were very involved with the hospitalized aged member. Lissitz noted that most families experienced the hospitalization as a sign that they were not able to provide proper care which caused feelings of guilt, shame and fear. Of this he wrote:

> the family's presence becomes indispensable to the peace of mind of the patient, for by visiting they reassure him and themselves. The overwhelming majority of families act courageously in these trying situations and they usually assist the hospital in its program with the patient . . . There is greater assumption of responsibility by the family as the patient becomes increasingly or completely dependent.[2]

In their study of 76 aged nursing home patients and their families in three Lansing, Michigan area nursing homes, York and Calsyn found a high degree of continued contact between the institutionalized aged in their sample and their families. They reported that the average number of visits by family was 12 per month. Only two families out of the 76 visited less than monthly. Frequency of visiting was not related to degree of impairment, but was found to be related to the quality of the pre-existing relationship.[3]

One study reviewed had as its sole purpose an identification of

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[1]Theodore Rosen, "The Significance of the Family to the Resident's Adjustment in a Home for the Aged," Social Casework (May 1962), p. 239.

[2]Samuel Lissitz, "Patient-Family Interrelationships in a Geriatric Hospital," Gerontologist, 2 (September 1962), p. 135.

[3]Jonathan L. York and Robert J. Calsyn, "Family Involvement in Nursing Homes," Gerontologist, 17: 6 (December 1977), pp. 500-505.

the ways in which families cooperate with long-term care facilities in the care of their aged members. The research, "Care of the Aged: A Shared Function" was undertaken by Dobrof with a sample of 247 institutionalized aged in five nursing homes in New York City. Dobrof's findings support other studies with respect to the availability of kin. Seventy-seven percent of these aged persons had family available. Predominant among these family members were adult children (41 percent) followed by nieces and nephews (18 percent), siblings (15 percent) and grandchildren (ten percent). Cousins and in-laws were available for some. Only 2.3 percent of the sample still had a living spouse.[1]

In her research, Dobrof placed a major emphasis on visiting as a sign of family involvement. As she noted, many of the tasks which families perform for the institutionalized aged take place during the course of visiting. Although her study did not determine whether relatives visited as a group or rotated their visits, there was substantial evidence of visiting by family members. Sixty-nine percent of the sample had regular visits from family members. Of these, 44 percent had weekly visits; another 13 percent had at least bi-monthly visits and an additional 13 percent had at least monthly visits.[2] Such a finding contradicts the stereotype of the institutionalized aged as either without family or as "dumped by uncaring and selfish children." The purposes for visiting were identified as tension management, the discussion of "important things," giving of comfort and advice, bringing of gifts and food treats, and family surveillance of the quality of

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[1] Dobrof, "Care of the Aged: A Shared Function," op. cit., p. 411.

[2] Ibid., pp. 355, 359.

care being provided by the institution.[1] Dobrof noted that most of family contacts with staff took place during visits. Visits, therefore, provided an opportunity for conferences with staff about:

> room and roommate assignments, special diets, appointments with medical specialists, lost or stolen personal possessions, dissatisfaction with the quality or availability of nursing and personal assistance services . . . such contacts were usually to express dissatisfaction, register complaints, demand better service or to insist on change. . . .[2]

In addition to visits, there were other patterns of contact. Dobrof found that 74.3 percent of her sample received regular phone calls from family and friends, letters and greeting cards. Many residents and their families participated in taking trips and excursions, exchanging gifts or money and visiting the homes of other relatives.[3]

When asked about more instrumental task performance, respondents indicated that 69 percent received special food treats from family members, 49 percent received clothing; 47 percent received items such as televisions and radios; 47 percent had family members who did shopping or ran errands for them and 18 percent were provided with personal care assistance from family such as bathing, grooming of the hair and nails or feeding.[4]

It can be said that in the performance of these tasks, families were not only addressing the most personal and idiosyncratic needs of residents, but also maintaining established cultural patterns and customs. An example of this would be the home cooked ethnic dish which

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[1] Ibid., p. 362.

[2] Ibid., p. 17.

[3] Ibid., p. 361.

[4] Ibid., p. 375.

family would bring as a special food treat. Such items were usually not found on the institutional menus.

Dobrof illustrated this with two vignettes, interestingly both are from Black families who constituted only 11 percent of her study sample. She wrote:

> In Institution IV which had the most ethnically heterogeneous population, there was a daughter of a man from the British West Indies who brought and ate with her father a full course meal, featuring an ethnic fish dish which she prepared and which was the delicacy he most craved. And there was the son of a Black man, who had been raised in the rural South, whose response to the question was, "Soul Food, cooked with tender loving care."[1]

Several variables were found to be related to the family's willingness and ability to play a role within the institutional setting. Among these were, family size and number of persons in the network; sex of key family member with females playing a more significant role; and the size and organizational complexity of the nursing home. Where the nursing home was large and very bureaucratic and where no special efforts were made to reach out to families in such settings, families played a much smaller role in the resident's care.

Summary

This review of the related literature has focused on three areas: (1) factors which place aged Blacks at risk of institutionalization and factors which lessen the risk; (2) the nursing home experience for Blacks; and (3) the role of the family within the nursing home.

With respect to the first area, data indicate that to the extent

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[1] Ibid., p. 383.

that advancing age, poor physical health and lack of spouse place an individual at risk of institutionalization, Blacks are equally, if not more at risk than whites. However, the relative advantage which Black aged appear to have with respect to availability of children and assistance from children, act to offset these risk factors. There is evidence that assistance from children may vary by socioeconomic status, sex of the adult child and sex of the parent, geography (i.e., rural vs. urban living), and recency of migration. Findings of studies reviewed suggest that the level of assistance which Black families give to their aged members, and strong cultural attitudes of filial responsibility, may account in part for the lower admission of Blacks to nursing homes.

In relation to the second area addressed in the literature review, current research studies on minorities in long-term care facilities indicate that factors other than demography also affect nursing home utilization. Discriminatory policies in referral and admission of minorities to nursing homes were noted by several writers. For those aged minorities who have been admitted, issues of culturally relevant programming have been raised. Findings specific to Blacks in nursing homes indicate that predominant issues are Black representation on the staff, use of ethnic foods, and appropriate social activities for a group whose work patterns left little time for the development of leisure activities.

Finally, the studies on maintenance of family relationships after institutionalization indicate that families do continue to play a meaningful role in the lives of many aged residents. There is evidence of regular visiting by families and the performance of many tasks

which seek to meet the more idiosyncratic needs of the elderly resident. Such evidence counteracts the stereotype of all nursing home residents as isolated, lonely individuals with no available family or meaningful family contact. Most of these findings are based on samples of white, primarily middle-class aged in institutions. It is hoped that the research reported here will add to this knowledge base by determining the extent to which these findings are applicable to the situation of the Black institutionalized elderly and their families.

CHAPTER III

CONCEPTUAL FRAMEWORK, HYPOTHESES AND OPERATIONAL DEFINITIONS OF STUDY VARIABLES

The major theoretical construct of this study, shared function, rests on Litwak and Meyer's Balance Theory of Coordination. There is a need to specify the aspects of this theory prior to the operational definitions of variables.

Some theorists of social behavior, like Talcott Parsons, have argued that in the increasing urbanized and highly mobile modern industrial society, one type of family structure is best suited to survive--the nuclear family. This family structure (composed of husband and wife and their dependent children) is small and freed from the obligational and economic bonds which in the past tied it to an extended family network. It is, therefore, best suited to thrive in a social economy which requires freedom of movement and allegiance to rationalistic rather than familistic norms. They argue further that the nuclear family functions best when it is isolated from the bureaucratic organizations which coexist in the same social order. This is the case because the primary group and bureaucratic organization have antithetical natures, norms, rules and values--all of which place them in a state of perpetual conflict.[1]

[1]See Talcott Parsons, "The Social Structure of the Family," in The Family Function and Destiny, ed. by Ruth N. Anshen (New York: Harper, 1959).

One major assumption of the Parsonian view of the modern social order is that primary groups and bureaucratic organizations operate according to different sets of rules and expectations. Primary groups operate according to an affective system of evaluation which places importance on personal and face-to-face contact. Bureaucratic organizations operate on an instrumental basis where the stress is on impersonality, specificity, professionalism, and the use of rules.

A second major assumption is that the activities of the primary group are for the most part replaceable by those of the formal organization. If a formal organization can perform a task as well or better than the family, there is no need for the family to assume the task. The bureaucratic organization is viewed as the most efficient means of achieving most social goals because of its professional expertise and economies of scale.

Other sociologists have questioned the validity of these assumptions. They base their dissent on the growing evidence from recent sociological research which shows that formal organizations and primary groups do not function in isolation from each other. These findings indicate that formal organizations and primary groups are each suited to perform different types of tasks. These tasks are not transferable from one type of structure to the other.

Two sociologists who have taken issue with the Parsonian formulation are Litwak and Meyer, who have postulated an alternative view of the relationship between bureaucracies and primary groups. They refer to this theory as the "Balance Theory of Coordination." This theory suggests that bureaucracies and primary groups have complementary rather than antithetical natures. Each type of structure contributes

to the achievement of desired social goals in its own unique way. Rather than replacing the primary group, the formal organization must find ways to coordinate a shared working relationship with the primary group. The emphasis is on communication and coordination, rather than isolation and replacement.

Litwak and Meyer note further that there is a basic dilemma which must be faced by any theoretician of interorganizational relations. This dilemma is created by the coexistence of two apparently antithetical propositions: (1) The contributions of both bureaucratic organizations and primary groups are frequently necessary to achieve maximum social control in a mature industrial society, and (2) the characteristics of bureaucracies and of primary groups tend to make them incompatible, if not antithetical, as forms of social organization.

They reason that any theory of coordination must avoid two kinds of errors. These errors relate to the destructive effects of either too much distance between the bureaucracy and the primary group or too much closeness between the two. Either extreme is dysfunctional, so a middle ground must be sought if the cooperative relationship is to succeed in goal attainment. Such deductive reasoning, supported by growing empirical evidence, leads finally to the specification of Litwak and Meyer's Balance Theory of Coordination:

> Optimum goal attainment is most likely to occur when coordinating mechanisms develop between bureaucratic organizations and external primary groups that balance their relationship at a midpoint of social distance where they are not too intimate and not too isolated from each other. This formulation requires recognition of the importance of a variety of mechanisms of coordination, ranging from those

> capable of bridging great social distances to those capable of increasing distance, while maintaining communication.[1]

In the context of the present research, the social goal is care of the institutionalized Black aged person. The bureaucratic organization is the nursing home. The family is the primary group. Thus all the necessary components for an application of the Balance Theory of Coordination are present. The principal study concept of "shared function" is Dobrof's restatement of the Balance Theory in terms of a specific social goal which is care of the institutionalized aged. It is Dobrof's reformulation which hypothesizes, as its parent theory does, that the social goal of caring for the frail elderly will be most effectively attained where the long-term care facility and the family share in the task. The degree to which this hypothesized set of relationships has relevance for Black families and nursing homes is one of the central research questions of this study.

Patterning of Variables: Application of the Shared Function Thesis

There are several independent variables in the study which relate to the facility, the family, and the aged resident respectively. They are:

1. Organizational complexity and size of the facility
2. Ethnic orientation of the facility
3. Structure and resources of the family

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[1] Eugene Litwak and Henry J. Meyer, "A Balance Theory of Coordination Between Bureaucratic Organizations and Community Primary Groups," Administrative Science Quarterly, 11 (June 1966), p. 38.

4. Ethnic orientation of the family

5. Resident's age

6. Resident's sex

7. Resident's physical health status

8. Resident's mental health status

9. Ethnic orientation of the resident

10. Congruence in ethnic orientation as between the resident and the nursing home

11. Congruence in ethnic orientation as between the family and the nursing home.

The dependent variables in the study are:

1. Mechanisms of coordination used by facility

2. Mechanisms of coordination used by the family

3. Degree of social distance expressed by family

4. Degree of shared function

    a. Degree of visiting by family
    b. Extent and nature of task performance by family

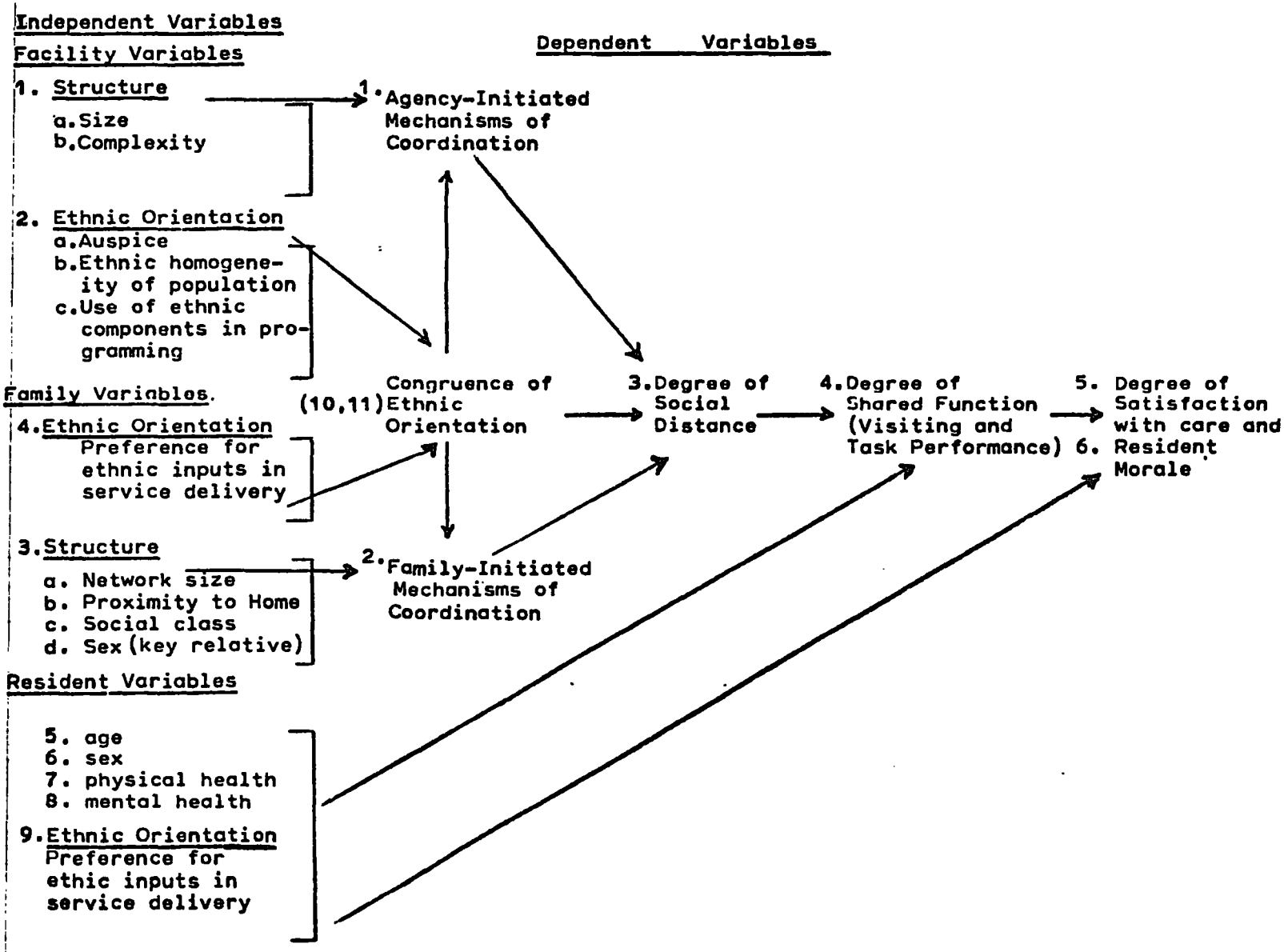
5. Satisfaction with care as expressed by residents and family members

6. Resident morale.

The theoretical model which appears on the following page illustrates the hypothesized relationships of the study variables.

The theoretical model can be broken down into a set of hypotheses which help to partialize the complex set of relationships suggested by the model. These hypotheses can be stated as follows:

CONCEPTUAL MODEL OF HYPOTHESIZED RELATIONSHIPS



Statement of Study Hypotheses

H_1: Congruence of ethnic orientation will be a greater determinant of social distance and shared function than the structural features of either the nursing home or the family.

H_2: Where there is congruence in ethnic orientation, more mechanisms of coordination will be used by both the facility and the family in working with each other.

H_3: There will be a relationship between the ethnic orientation of the facility and the nature of task performance by the family, such that:

a. In the facilities with a stronger Black ethnic orientation, tasks related to the preservation of cultural patterns will be performed by the facility on a uniform basis.

b. In the facilities with a stronger non-Black ethnic orientation tasks related to the preservation of cultural patterns will be performed by the family or close friends who act as functional kin.

H_4: There will be a relationship between degree of social distance from the facility expressed by the family and degree of visiting.

H_5: There will be a relationship between social distance from the facility expressed by the family and the degree of familial task performance within the facility.

H_6: There will be a relationship between the degree of family task performance and satisfaction with care as expressed by both the resident and the family.

H_7: There will be a relationship between degree of shared function and level of resident morale.

H_8: Personal characteristics of the aged resident (specifically age, sex, physical health status and mental/emotional health status) will relate to the degree of family visiting and task performance.

Conceptual and Operational Definitions of Variables

The major study variables are now defined conceptually, to clarify their function in the theoretical model. They are also defined operationally, to indicate how they are actually measured in the study. The independent variables are grouped into two dimensions: (1) structural and organizational variables, and (2) ethnic orientation.

Structural and Organizational Variables

The Shared Function Thesis suggests that the structure and complexity of the nursing home would be a determinant of its ability to apply time, resources, and manpower to the employment of mechanisms of coordination in engaging families. In addition, the degree of bureaucratic complexity in staffing patterns and operations could affect the family's ability to negotiate "the system" and employ any mechanisms of coordination available to it. In this research the structure and organizational complexity of the nursing home is defined as a function of its size (resident population, staff size, and number of departments) and the degree of complexity in operations suggested by the organizational size. Data on these organizational characteristics were obtained through a series of questions in the Administrator Interview on the size and complexity of the facility (see Appendix A, 1-4, I-XIII).[1] For the purposes of data analysis, a "complex"

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[1] For reference purposes, citations to study instruments are made in the description of operational definitions. Citations include (Appendix, pp., item no.). A detailed description of the study instruments appears in the Methodology chapter.

facility will be one which serves over 200 residents.

Structure/organization of the family. As with the facility, the family's ability to reach out and coordinate caring functions with the nursing home would be affected by its available resources, both material and manpower. Family structure was operationally defined as the size of the family network, family proximity to the nursing home, social class (i.e., education and occupation) of key family members, and sex of family members most involved with the facility. All of these variables are viewed as affecting the family's ability and understanding of how to negotiate the nursing home system. Data on each of these areas were collected by means of a series of questions in the Family Interview (C, 1:1-9 and C, 2:12-13).

Resident characteristics. Resident-related variables which are hypothesized as affecting family motivation and ability to share in caring functions are the resident's age, sex, and degree of frailty. The last refers to both physical health status and mental health status. As studies cited in the literature review have shown, these are variables which appear to be related to inter-generational helping in the community. A series of questions on the demographic characteristics of the resident is included in the Resident Interview (B, 1:1-11). Physical and mental/emotional health status were operationalized by staff ratings of the resident on a functional health status scale which included such areas as general physical health, sensory acuity, appetite, sleep patterns, ambulation, ability for self-care in the "physical health" domain and mental alertness, reality orientation, judgment, memory, sociability and control of emotions in the "mental/emotional health" domain (D, 6:11).

Ethnic Orientation

With respect to ethnic orientation as a variable, the study seeks to assess the ethnic orientation of the facility, the resident, and the family, as well as the degree of congruence among them. Especially important is the identification of the "ethnic" nursing home's role in the provision of care in culturally congruent ways. It is hypothesized that because the nursing home is "ethnic," the role of the Black family in shared functioning may be different than it would be in a "non-ethnic" nursing home. Litwak and Dono have suggested that ethnic institutions are unique because of their "in-between" group structure. They possess characteristics of both the primary group and more formal organizations by virtue of the ability to extend, "primary group demand for non-instrumentality to large numbers of people."[1] Additionally, it could be hypothesized that congruence of ethnic orientation will affect degree of felt social distance from the facility, which in turn will affect family participation in care.

Ethnic orientation of the facility refers to the racial homogeneity of the resident population and staff; as well as auspices or sponsorship of the nursing home. Using a scale developed by Jenkins in "Ethnicity and Child Welfare: The Ethnic Agency Defined,"[2] each administrator was asked to give a profile of his/her nursing home in terms of racial heterogeneity-homogeneity of resident population

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[1]Eugene Litwak and John Dono, "Forms of Ethnic Relations, Organizational Theory and Social Policy in Modern Industrial Society," (unpublished paper, Columbia University, December 21, 1976), p. 8.

[2]Shirley Jenkins, "Ethnicity and Child Welfare: The Ethnic Agency Defined," Project Report of the Study Ethnicity and Child Welfare, Columbia University, June 1977.

(percent of Black residents served); number of Black staff at all professional and direct service levels; use of cultural components such as ethnic food, art, music, dance and religious services in normal caring routines, as well as personal attitudes on the desirability of using these components in service delivery.

Jenkins describes the scale as follows:

> The final instrument to measure agency ethnic commitment comprises 25 items, and is organized in three parts. Part I, "Culture" has as its core use of ethnic materials such as food, art, music, holidays, history and one item of a different but apparently related order, the ethnicity of the director. Part II, "Consciousness" refers to the ideological position of the agency. Items ask about support of ethnic institutions, leadership on ethnic issues, pride in ethnic culture, the development of separate ethnic institutions and the level of ideological commitment on the continuum from "equal rights" to "cultural pluralism" to "ethnic identity." Finally, Part III, "Matching" includes items on the percent of ethnic clients, the ethnic composition of staff, the preferences on staff composition, agency policies on recruiting and matching staff and clients.[1]

A version of this scale, slightly modified to put the issues in the context of institutional services for the aged rather than child welfare, is included in the Administrator Interview (A, 8). Administrators were also asked to indicate the importance of each aspect of cultural programming to them personally.

Ethnic orientation of the resident refers to the degree of importance (i.e., preference) which he/she places on having the nursing home staffed by members of the same ethnic group as his own and the inclusion of cultural components (e.g., ethnic foods, music, arts, etc.) in the normal routines of the facility. Resident ethnic orientation will be measured by the Ethnic Commitment Attitude Scale developed by Jenkins, previously cited. A version of this scale which puts the

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[1] Ibid., p. 53.

issues in the context of institutional long-term care was included in the Resident Interview (B, 3:1-13).

Ethnic orientation of the family will be measured by the Jenkins Ethnic Commitment Attitude Scale as included in the Family Interview (C, 10:1-12).

Congruence of ethnic orientation refers to the degree to which the resident and the facility and/or the family and the facility have similar emphases on ethnic programming in service delivery. "Congruence" will be said to exist where clients "high" in ethnic commitment are in Ethnic Nursing Homes or where clients "low" in ethnic commitment are in Non-Ethnic Nursing Homes. "Incongruence" will be said to exist where clients "low" in ethnic commitment are in Ethnic Nursing Homes or where clients "high" in ethnic commitment are in Non-Ethnic Nursing Homes.

Definition of Dependent Variables

Use of mechanisms of coordination refers to mechanisms used by the facility in working with families and by families in working with the facilities. In her study, "The Care of the Aged: A Shared Function," Dobrof identified 15 mechanisms of coordination which nursing homes and other long-term care facilities have used in reaching out to families of residents. She also identified 13 mechanisms of coordination used by family members in reaching out to the facility and its staff. For the present study, these 28 mechanisms have been developed into two scales which measure the frequency with which they are used by the facility (A, 6-7) and the family (C, 8 and C, 6:38).

In the theoretical sense, social distance refers to "the degree of distance a family feels from a bureaucracy where their values differ or where their capacity to implement common values differ."[1] In this study, social distance will be measured by a series of questions in the Family Interview which ask family members to assess their degree of comfort in relating to staff and their opinion on whether or not they feel the facility encourages visits from family (C, 6:34; C, 7:41-44). In addition, some assessment of the family's guilt around the placement of their aged relative is attempted under the assumption that felt social distance may be a function of guilt feelings. Five items expressing potential manifestations of family guilt were taken from a larger questionnaire used by York and his associates in the Nursing Home Training and Consultation Project undertaken in Lansing, Michigan.[2] These items include visiting without really wishing to; feeling guilt; feeling that the decision to put the aged relative in a nursing home was the wrong decision; shame at telling others that an aged family member was institutionalized; and feeling that if the decision had to be made again, an alternative to the institution would be tried. Family members were asked to indicate how "true" these statements were of their own feelings (C, 7:45-49).

Shared function refers to the degree to which family members participate in the care of their aged relative. In this research shared function is assessed by two separate but related indicators: (1) the degree of visiting by available family members, and (2) the nature of

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[1] Litwak and Meyer, op. cit., p. 53.

[2] Jonathan L. York and Robert Calsyn, "Family Involvement in Nursing Homes," Gerontologist, 17: 6 (December 1977), pp. 500-505.

tasks performed by family members during the course of visits.

Staff were asked in the Social Service/Nursing Staff Checklist to indicate who of the available family members visited the resident and how often (D, 2:8).

The same information was requested in the Resident Interview (B, 7:1) and the Family Interview (C, 5:31). On the basis of resident reported visiting patterns, the resident sample was divided into five categories:

(1) Residents with no significant others available

(2) Residents with significant others who never visit

(3) Residents with at least one visit yearly, but not as frequently as once a month

(4) Residents with at least one visit monthly, but not as frequently as once a week

(5) Residents with at least one visit weekly or more often.

These categories represent different visiting patterns based on frequency of contact. No consideration was given to whom the visitor was with the exception of volunteers. The visitor had to be someone not formally employed by or connected with the nursing home. These categories, either alone or collapsed, can be cross-tabulated with other key study variables. Residents with no known family were also included in this categorization since close friends, church members and former neighbors were considered "significant others." Data on visits for residents with no known family were collected in the Resident Interview (B, 9:1).

The other aspect of shared function is family task performance. Operational indicators of task performance developed by Dobrof were

adopted for use in this study.[1] These include:

Food treats
Shopping, running errands
Gifts of money
Gifts of clothing
Sewing and mending clothing
Personal care, grooming
Conferences with staff about care
Trips
Reading and playing games
Bringing books, newspapers, magazines.

Data on family performance of tasks were collected in the Resident Interview (B, 7-8:1-9) and the Family Interview (C, 6:34-37). As a final operational step and to facilitate statistical testing of study hypotheses, an attempt was made to create a "Task Performance" score which is a numerical function of the number of tasks performed by family members and the frequency of task performance.

Satisfaction with care was evaluated by both residents and families. It refers to their assessment of satisfaction with the physical surroundings of the facility, medical and nursing care, food, social activities, financial arrangements, emotional support and counseling, staff attitudes toward residents, family involvement, other residents in the home, and accessibility of staff and administrator.

These factors were developed into a scale which allows residents and families to rate their level of satisfaction with each area of service from very satisfied to very dissatisfied (B, 2:1-11) and (C, 9:1-11). A satisfaction score was calculated from the cumulative ratings of each area assessed.

Resident morale refers to the resident's state of "happiness" or emotional well-being. It was operationalized by application of the

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[1]Rose Dobrof, op. cit., pp. 283-285.

Havighurst Life Satisfaction Scale (Havighurst, 1961). In addition, resident morale was evaluated by the staff (D, 1:7), the family (C, 9:11), and the resident (B, 2:11).

CHAPTER IV

SAMPLING DESIGN AND DATA COLLECTION

Estimates of the Study Population

Before discussing the sampling strategy in this research, some data on the size of the study population are required. There are no precise figures on the number of Black aged in long-term care in New York City. The estimate used by the New York City Office on Aging is four percent of the Black population aged 65 and over. As of 1976, there were 92,396 Blacks in New York City aged 65 and over, which would suggest that approximately four percent or 3,695 of this number would be institutionalized.[1]

In order to locate the sample, it was necessary to estimate the number of Black aged in institutional long-term care by auspices of the facility. One way to approach this is to assume that the distribution of Blacks in long-term care, by auspices of facility, would follow the same pattern as that of whites. In order to establish the pattern for whites, the Health Facilities Directory (1976): Nursing Homes was consulted to ascertain the number of certified nursing home beds in

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[1]Barbara Dickson Hanrieder, "Demographics of New York City Elderly as of 1976," Facts for Action Series (New York City Department for the Aging, November 1978), p. 3.

New York City.[1] Staten Island was excluded because of the small number of Blacks who reside there compared to other boroughs. According to this document, there were 26,235 certified nursing home beds in New York City (excluding Staten Island). Of these, 15,741 or 60 percent were in proprietary facilities; 8,853 or 34 percent were in voluntary facilities and 1,721 or six percent were in public facilities (these were usually large public hospitals). If this distribution also applied to Blacks, one would expect that 60 percent or 2,217 of the institutionalized Black aged would be in proprietary facilites, 34 percent or 1,256 would be in voluntary facilities and six percent or 222 would be in public facilities. However, given the overrepresentation of Blacks in public agencies of other service types, there was some uncertainty as to the validity of the equal distribution assumption.

To explore the appropriateness of these estimates, field staff were contacted at the New York City Department for the Aging.[2] There were no statistics available on the number of Blacks in care by auspices of the nursing home. Based on their observations, however, they questioned the assumption of equal distribution and the estimates which it produced. In their opinion, the percentage of aged Blacks served by voluntary nursing homes was closer to 50 percent rather than 34 percent. They noted that several Black voluntary nursing homes were built in recent years from funds provided under Title 28-A. These State funds

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[1] New York State Department of Health, Program of Health Care Standards and Enforcement, Health Facilities Directory (1976): Nursing Homes, 1976.

[2] Many thanks to Valerie Levy and Ann Coyne of the New York City Department for the Aging for their assistance. And I would also like to thank Vicki Ashton of the CSS Older Persons Service for her help in this regard.

were allocated in 1969 to meet a severe shortage of nursing home beds in the State. Preference went to the voluntary facilities. The percentage in proprietary facilities was therefore probably closer to 20 percent rather than 60 percent. It was felt that in proprietaries issues of race and class in admission procedure were most likely to occur. On the other hand, the six percent estimate seriously underestimated the number of aged Blacks in the public facilities. The percentage of Blacks in public facilities was felt to be closer to 30 percent, and one large public hospital in particular was mentioned as serving a substantial number of Black aged clients. With respect to the racial composition of the nursing homes, consultants felt that most nursing homes could be roughly divided into those that served a majority of nonwhite clients and those which served a small percentage of nonwhite clients (i.e., under 15 percent).

Based on the information supplied by the field staff at the New York City Department for the Aging, it was decided to draw the study sample from the public and voluntary facilities, since an estimated 80 percent of the population would be served by these types of facilities. In addition, access to the proprietary nursing homes was felt to be problematic. The period of sample selection was one of intensive bad press for several proprietary nursing homes in New York City because of a series of investigations which were held by State and City officials on admission, funding and operating procedures in these Homes. The opinion expressed by several professionals consulted in the long-term care field was that cooperation from the proprietary facilities would be problematic.

With the elimination of the proprietary facility population, the

population of interest became the estimated 2,956 aged Blacks served by voluntary and public facilities in New York City. Because one of the critical independent variables in the study is the ethnic orientation of the facility (which included racial homogeneity of the resident population), it was important that the study sample be drawn both from Black aged in facilities which served a majority of Blacks, and those in facilities which served a minority of Blacks. Another important independent variable is the organizational complexity of the nursing home as a function of its size. These two variables were given priority in the selection of the sample, with voluntary vs. public auspices a less important factor. A sample of 165 residents was desired. This would represent a five percent sample of the 2,956 estimated population (150) plus a ten percent margin for refusals (15).

Selection of the Nursing Homes

Using the dual criteria of ethnic auspices and organizational size, ten nursing homes were identified by Office for the Aging staff as serving Black residents and also providing variance on the two independent variables. These ten homes fell into four groups: Group I were the small nursing homes serving a majority of Blacks labeled ethnic (2); Group II were the large nursing homes serving a majority of Blacks labeled ethnic (2); Group IV were large nursing homes serving a minority of Blacks labeled non-ethnic (1), and Group III were small nursing homes serving a minority of Blacks labeled non-ethnic (5). Group II included the only public facility, a large public

hospital. A "small" facility was defined as one with a total resident population of 200 or less. Large nursing homes were defined as those serving over 200 clients. Since the desired sample was 165, the sampling design called for taking 41 residents from each of these four groupings. The following table presents data on the ten nursing homes comprising each of the four groups with respect to total population, percentage of Black residents, and number of Black residents.

TABLE 1

PROFILE OF THE TEN NURSING HOMES IN STUDY SAMPLE BY TOTAL RESIDENT POPULATION, PERCENTAGE AND NUMBER OF BLACK RESIDENTS SERVED

Facilities by Group	Total Population	Percentage of Blacks	Number of Blacks
Group I (small, ethnic)			
Facility 1	123	80	98
Facility 2	200	98	196
Total	323	91	294
Group II (large, ethnic)			
Facility 3	295	60	177
Facility 4	976	40	390
Total	1,271	45	567
Group III (small, non-ethnic)			
Facility 6	200	5	10
Facility 7	157	5	8
Facility 8	80	5	4
Facility 9	93	5	5
Facility 10	197	5	10
Total	730	5	37
Group IV (large, non-ethnic)			
Facility 5	447	12	54

The Administrators of each of the ten nursing homes were contacted by letter. A study prospectus was enclosed with the letter for their review and consideration (see Appendices F1 and F2). Several follow-up calls and letters were made to each of the facilities in an effort to arrange a meeting to discuss the study and their participation in it. Facilities 1, 2, and 3 which serve a majority of Black residents agreed to meet and subsequently agreed to participate in the study, as did Facility 5 which served a 12 percent Black clientele. Because of its size, Facility 5 had a pool of 54 Black potential subjects. The Administrator of this facility felt that 20-25 of these 54 subjects were able to be interviewed. In addition, the facility had reportedly been the subject of many research studies and prided itself on its availability to be used in this way. The next facility which agreed to meet was Facility 6, a small nursing home serving a 3.5 percent Black clientele. A meeting was held with the Administrator of Facility 6 and he agreed, somewhat cautiously, to participate in the study. It should be noted that each of these Administrators took the research request to the Board of Directors for final approval. This process took from 1-3 months across these five facilities, in most cases approval was forthcoming within a month and a half of the request.

Four of the five small, predominantly white nursing homes which reportedly served about a five percent Black clientele refused to participate in the study. It was noted previously that the Administrator of the one facility which did agree to participate out of this group did so cautiously. The initial interview with him confirmed the reason suspected for the low response rate from this group. There was great concern expressed about how the study data would be used in

view of the fact that so few Blacks were in residence. The Administrator wanted it to be known that his facility had actively reached out to Black families and had never denied any applicant admission on the basis of race. In a social climate created by issues of affirmative action and equal access for minority consumers of service, there was apparently some fear and suspicion about the study and the implications of any study findings. Such a response was not totally unexpected, although it was hoped that after an initial meeting to explain the study purpose (with all assurances of confidentiality) these facilities would agree to participate. This, however, was not the case. With respect to the original sampling design, facilities in the fourth grouping are not really represented. The one participating facility from this group served only seven Black residents.

Finally, in the second grouping there was the only public facility--Facility 4. As Table 1 indicates, an estimated 390 Blacks resided in this large public hospital. Many of these were thought to be aged based on consultant observation. Three months after an initial letter and several follow-up letters, the Administrator of this facility replied in writing to the request for participation in the study. He explained that the usual procedure in his facility was for one department to sponsor outside research. This department's head would put the research request before the Research Committee and once approval had been given, would oversee the research activity. The Social Service Department was suggested as the one most appropriate to sponsor this study. The study prospectus and contact letters were forwarded to the Director. During this period data collection at the other nursing homes was taking place. Since public vs. voluntary auspices was not a

variable in any of the study hypotheses, it was decided to proceed with the data collection from the willing voluntary facilities. When the data collection in the voluntary facilities was nearly complete, the public facility's Social Service Director responded with an offer to meet to discuss the study. In a follow-up phone call a rather elaborate research approval process was delineated. It appeared that even with Departmental sponsorship, the approval process would take at least another month. Because inclusion of a public facility was not essential to the study purposes, a decision was made not to include this facility in the study sample. An additional rationale was the uneven distribution of voluntary to public (5 to 1). The elimination of public vs. voluntary auspices as a variable, also removed one other factor which might serve as a rival hypothesis for observed differences on major study variables.

Although they do not include proprietary or public facilities, the sample of facilities included in the study are very good with respect to representation of the Black voluntary facilities in New York City, both small and large. The following table provides an organizational profile of the five nursing homes which ultimately comprised the study sample.

The fact that these five nursing homes are all voluntary facilities limits the generalizability of the study findings to Black aged who reside in voluntary nursing homes. These homes were also selected on a non-random basis. The inability to identify the actual population of facilities serving Black aged in New York City made a random sampling procedure impossible. The other major limitation is the lack of response from the smaller facilities which serve small numbers of

TABLE 2

PROFILE OF THE FIVE NURSING HOMES
PARTICIPATING IN THE STUDY

Characteristic	Nursing Homes in the Study				
	I	II	III	IV	V
Founding Date	1966	1973	1976	1875	1875
Auspices (Original)	Voluntary Baptist Church	Voluntary Non-Sectarian	Voluntary Non-Sectarian	Voluntary German Non-Sectarian	Voluntary Lutheran Church
Number of departments	12	11	14	14	10
Staff size	150	213	316	575	200
Resident population	123	200	295	447	200
Number of Black residents	98	196	177	54	7
Percentage of Black residents	80	98	60	12	3.5

Black aged. However, the five facilities included serve a total of 532 Black aged clients, which represent 29 percent of the 1,847 aged Blacks estimated to reside in voluntary nursing homes in New York City, excluding Staten Island. Thus approximately 30 percent of the identified population reside in the five homes in the study sample.

A few key patterns emerge from these data which are noteworthy. Founding date indicates that facilities I, II, III are relatively new

facilities compared to facilities IV and V. These are the facilities which serve a majority of Black residents. The recency of their development suggests a growing need for such voluntary facilities in the Black community and/or a growing acceptance of the use of institutional care as a viable option for the frail Black elderly. This is not to say that Black nursing homes have not existed in the past. They have, but many were closed when building and safety requirements became more stringent. Their meager funds would not cover the kinds of major renovations which would have been required to be in compliance with the new codes. The facilities visited are all modern, attractively furnished and designed. Facilities IV and V are considerably older and "well-established." Both show evidence of fairly recent expansion, with the addition of new buildings and wings as the original facility was outgrown.

With respect to original auspice, there is great variation, as one would expect with voluntary nursing homes. Two were sponsored by churches, one by a Black Baptist Church, one by a white Lutheran Church, one was co-sponsored by a Black Church and a Black business concern, one was solely sponsored by a Black business concern, and the other began as a philanthropic home for German aged. All are now non-sectarian and open to any who wish to make use of their services.

With respect to size and organizational complexity, there was variation across the five facilities. There was, however, a common pattern of services provided which is typical of most licensed nursing homes. These services included nursing care, medical care, dietary services, social services, security, maintenance and housekeeping, rehabilitative services (medical and recreational), and

volunteer services. The departments which organized and provided these services varied in size and organizational complexity across the five facilities. The usual pattern, which would be expected, was for larger facilities to have more complex departments of larger size. These five facilities, then, can be roughly divided into those which are organizationally "less complex" (i.e., Facilities I, II and V) and those which are organizationally "more complex" (i.e., Facilities III and IV). In this research, such a categorization was made based on the variables of number of departments, staff size, and size of resident population. Facilities III and IV serve over 200 residents which would require a large staff and would seem to necessitate a greater degree of organizational complexity. There was some support for dividing the facilities in this way, as evidenced by the administrator's response to questions on administrative style. Facilities III and IV were less characterized by flexibility in roles among staff and more by sharper lines of function, channels of command and accountability. The principal investigator used two other "informal" indicators of organizational complexity. These were the number of channels which had to be gone through to have access to the administrator for both research approval and interview and the bureaucratic complexity of the research approval procedure. On the basis of all these indicators, the facilities were divided into those which are "less complex" and "more complex" for the purposes of hypotheses-testing where organizational complexity is a key variable. The qualifiers "less" or "more" are used with the recognition that such a categorization is "gross" at best given the variations which do exist across each of the five participating nursing homes.

Selection of the Resident Sample

Knowing that four of the five small non-Black nursing homes would not be in the study, the desired sample size was reduced from 165 to 126, a drop of 39 cases which were estimated to be available from the four nonresponding nursing homes. There were sufficient numbers of Black residents in the facilities which comprised the three other groupings, however, to obtain a sample of 40 Black aged residents from each grouping. Those facilities which served a large percentage of Blacks would permit a random sample to be drawn. The facility was asked to provide a list of all residents judged by staff to be physically and mentally able to complete an hour interview. Judging by the size of the lists in comparison with the total resident population, the severity of impairment was very high. A different strategy was used in the predominantly white nursing homes. Because of the smaller available pool of Black aged residents, all residents who were not judged by staff to be incapable of completing an interview were approached.

The limitations imposed by this strategy are that (1) resident selection relied on staff judgments, and (2) the residents in the study sample represent the healthier population among the institutionalized Black aged. Using these methods a sample of 117 residents was drawn. Statistics on the response rate from these 117 subjects appear in Table 3. Each subject was mailed a letter asking permission for an initial interview to establish personal contact and explain the study purpose (see Appendix F4). If the subject agreed to participate, a date and time for the Resident Interview was arranged.

TABLE 3

STATISTICS ON THE RESPONSE RATE FROM BLACK AGED RESIDENTS SELECTED FOR INCLUSION IN THE STUDY BY FACILITY

	Total	Grouping 1		Grouping 2	Grouping 3	Grouping 4
		I	II	III	IV	V
Sample Drawn	117	20	38	25	31	3
Residents Inter-viewed	93	19	31	22	18	3
Resident Refusals	24	1	7	3	13	--

As Table 3 indicates, a total of 93 residents were interviewed for this study. Ten of the 19 residents interviewed at Facility I constituted a pre-test group. Since only minor revisionswere made in the study instruments they have been included as part of the study sample. As the data show, the resident refusal rate was 20 percent. It was expected that refusal rate would be closer to ten percent, which may have been overly optimistic. The refusal rate appears to be related to the procedures for obtaining informed written content. To illustrate this relationship, the consent procedures will now be described.

Procedures for Obtaining Informal Written Consent

After an oral explanation of the study, residents were asked if they were willing to be interviewed. If the response was in the

affirmative, they were asked to sign a written consent form (see Appendix E1 and 2). The form was usually read by residents who were literate and had good eyesight, otherwise it was read aloud and the signature of the resident witnessed by a member of the staff, usually the floor nurse. The family respondents were also asked to sign a consent form (see Appendix E3 and 4) when they were interviewed. It seems appropriate to note in this context, that most of the resident refusals occurred at the point where written consent was requested. Some potential respondents were quite willing to be interviewed, but were suspicious or fearful of signing anything. Even some of the facility staff were reluctant to "get involved" by witnessing the signatures of blind or illiterate residents. In some facilities, social workers were very cooperative in helping the study interviewers to explain to the resident that the consent form was for the protection of the resident, the nursing home and the research investigator. Some researchers have begun to address problems in obtaining informed consent with elderly populations, especially in light of the ever-growing complexity of many consent procedures.[1] In compliance with Human Subjects regulations of the U.S. Department of Health, Education and Welfare, the signed consent forms for this project have been submitted to the Columbia University Office of Projects and Grants where they will remain on file.

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[1] Julia Loughlin Makarushka and Robert D. McDonald, "Informed Consent, Research and Geriatric Patients: The Responsibility of Institutional Review Committees, Gerontologist, 19: 1 (February 1979), pp. 61-65.

Selection of Family Member Respondents

During the course of the interview questions about availability of family were asked. Of the 93 residents in the study sample, 64 or about 69 percent had family available. These 64 residents were asked permission to contact a member of the family for a family interview. The person usually specified was the person listed in the facility records as the "person to notify in case of emergency." None of the residents denied permission to contact the family. Names and addresses of family members were obtained through staff from agency records. Phone numbers were also obtained to facilitate follow-up calls. These 64 family members were mailed a contact letter briefly explaining the purpose of the study and indicating that a follow-up phone call would be made to request a date and time for an interview (see Appendix F5). Table 4 presents data on the response from family members.

As can be seen from the data in Table 4, the refusal rate from family members was twice as high as that for residents. It was not clear why the refusal rate was so high at the time of data collection. The issue did not seem to be procedures for obtaining consent as it was with residents. Family members would not have been informed of consent procedures until the time just prior to the interview and most refused to even arrange a time to discuss their participation in the study. A number of hypotheses could be put forth to explain the high refusal rate. One could be lack of sufficient efforts to engage the families. It is probably safe to reject this explanation given the efforts at repeated follow-up calls on the part of both interviewers and in some cases, facility social service staff who were willing to

TABLE 4

RESPONSE FROM FAMILY MEMBERS, BY FACILITY

	Facility					
	Total	I	II	III	IV	V
Family available	64	14	16	13	14	7
Family interviewed	27	4	8	7	5	3
Family refused	27	7	4	5	7	4
Refusal rate	42%	50%	25%	38%	50%	57%
Unable to locate[a]	10	3	4	1	2	1

[a]"Unable to locate" includes returned contact letters marked "addressee unknown," with no forwarding address if marked "moved," and where family members could not be reached after repeated phone calls to arrange for an interview.

endorse the study. After an analysis of data on family member responses to social distance items, another hypothesis became apparent. As will be discussed in greater detail in Chapter VII, the family members who agreed to be interviewed felt very good about the facility staff, expressed very little guilt about having an aged relative in a nursing home, and appeared to be heavily invested in maintaining contact with the institutionalized family member. There is, then, apparently a self-selection process in the family member interviews. It might be hypothesized that families who refused to be interviewed had feelings about the placement, the facility, and/or the resident which they did not wish to discuss.

Several statuses were represented among the 27 family members

interviewed. Nine of the family respondents were daughters, four each, respectively were sons, sisters and nieces, two were granddaughters and one each, respectively, were spouse, brother, other relative and godchild. The predominance of females among these family members is interesting and the same predominance was characteristic of the 64 available family members.

Logic of Data Collection Approach

With the exception of the Social Service/Nursing Checklist (see Appendix D), all other data were to be collected in face-to-face interviews. The interview was felt to be the best method of data collection, especially for resident and family interviews, given the affective quality of much of the desired information. It was felt that as much could be learned about how the resident and/or his family felt about the institutional experience from the "way" he responded as much as from "how" he responded.

All of the residents who were interviewed were interviewed face-to-face. Seventeen of the 27 family members who agreed to be interviewed preferred to be interviewed over the phone. For some scheduling was a problem and for others reasons were not given (or requested), but one might assume this choice afforded greater anonymity.

In-person interviews gave the study staff the opportunity to spend time in the facility, to observe the ethnic make-up of staff at several levels as a means of confirming reports by facility Administration. In addition, resident-staff interaction could be observed, even

if for limited periods of time. These observations added another dimension to the research.

The principal investigator did all of the interviews with administrative staff and 20 percent of the resident interviews. Graduate students in social work who specialized in the study of geriatric services did the remainder of the resident interviews and the family interviews. All of the student interviewers were Black because of the evidence from some previous research that interviewer-subject differences in race may cause bias when racially oriented material is part of the study protocol (Sherman, 1955; Jackson, 1967; Brieland, 1955; and Hyman, 1954). A week long training session was held with the student interviewers, during which the procedures for obtaining informed consent were explained. Role play was also undertaken to practice dealing with resident need for clarification and assurance. The role plays also served to help the student interviewers develop greater skill in timing the interview, keeping it focused, and recording exactly what was being said rather than an interpretation of what was being said.

Finally, in order to check the major study instrument for reliability, a pre-test was undertaken with ten residents as a basis for modifying the Resident Interview as needed. Very few modifications in wording were required, but what did become apparent was that the interview could prove too tiring for some residents to complete in one session. The Resident Interview was divided into "levels" with the most important data requested in the beginning so it would not be lost

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should the interview be terminated prematurely.

Description of Study Instruments

Study instruments were designed to collect a relatively wide range of data in as concise a manner as possible. For this reason, close-ended questions and rating scales were preferred. In addition, data on key study variables were collected from more than one source as a means of cross-validating responses of interviewees. For example, data on family visiting were collected from staff, residents, and family members using the same categories and frequency designations. Another example is resident morale, which was evaluated by two, if not three sources. Data from the Administrator Interview were checked, in part, against responses to similar items in the Social Service Director Questionnaire (see Appendix A1).

The following description provides an overview of the data collected in the study instruments. The data collection instruments are appended as noted.

Administrator Interview (Appendix A) sought data on the history and auspice of the facility; its size and staffing pattern; its Board or governance structure; an overview of services provided; referral sources, the admission procedure and problematic aspects of admission for Black clients; funding; organizational structure; administrative style; sanction for family involvement; outreach and coordination efforts used in working with families; and the ethnic orientation of the facility. In addition, administrators were asked if there were any special needs or problems particular to Black residents; what they felt accounted for the low utilization of nursing homes by Blacks; and if there were any difficulties in reaching out to Black potential

clients or their families.

The last five areas specified above were also addressed in the Social Service Director Questionnaire (Appendix A1).

The Resident Interview (Appendix B) sought data on demographic characteristics of the resident, prior living arrangements, satisfaction with care at the nursing home, self-evaluation of overall morale, special problems because of race and age, the Havighurst Life Satisfaction Scale, patterns of visiting from family members, tasks performed by the family while visiting (for residents without family tasks performed by friends, church members or volunteers), past patterns of interaction with family, friends and neighbors, and the decision-making process around placement including reasons for admission to the nursing home.

The Family Interview (Appendix C) covers areas such as family composition, family resources (education, occupation and income), the decision-making process and the family's role in it, past patterns of interaction with the aged relative (reciprocity of helping), current pattern of visiting, task performance by family members, family participation in activities in the Home, feelings of social distance or closeness to the facility and its staff, guilt around the placement, mechanisms of coordination used to outreach and work with the facility, family assessment of resident morale, family satisfaction with services provided, ethnic orientation of the family (Jenkins Scale), and the family's opinion on any special needs which Black residents have in long-term care.

The Social Service/Nursing Staff Checklist (Appendix D) asks the social service and/or nursing staff to provide data on the major reasons for the resident's admission, how the resident and the family accepted the decision to enter the nursing home, resident morale, patterns of visiting by family members and friends, evaluation of the resident's physical health status and evaluation of the resident's mental/emotional health status.

Confidentiality

All participating facilities, residents and family respondents were assigned a code number. Names or other data which could in any way specifically identify the respondent have not been used in this document. Residents and family members were assured that their names would not be used in the dissertation document or any other reports or publications which might develop from it. A perusal of the Resident Interview (Appendix B), the Family Interview (Appendix C), and the Social Service/Nursing Staff Checklist (Appendix D) will show that the resident's name appears only on the covering page. This facilitated interviewer location of the resident and allowed for monitoring of follow-up activities. Once the interview was completed, the cover page was removed and filed separately, leaving only the code number as the identity marker on the completed protocol.

Data were coded and keypunched using only code numbers to facilitate identification of the data source. Data analysis and reporting of findings will be based on aggregate data. Although individual responses to open-ended questions may be used as exemplary vignettes, the subject will not be referred to in any way which would make his or

her identity explicit.

All of the above procedures were reviewed by the Columbia University Human Subjects Review Committee and were approved as being in compliance with Federal and New York State laws on the protection of human subjects.

Internal Reliability and Validity

Data Collection and Coding Procedures

Several procedures were employed in the collection and coding of data to increase the reliability of data obtained. One procedure was the training of interviewers which has already been described. With respect to coding of the data, a standardized code guide was developed for the study instruments. An experienced student coder was hired to do a reliability check on coding. Fifty percent of the Resident Interviews and all of the Family Interviews were coded independently by the principal investigator and student. A reliability check on those cases which were coded in this independent manner showed a high degree of inter-judge reliability. Both sets of coded data were key-punched and run through the computer where answers to the same questions were correlated. On the close-ended items (which represent the majority of items comprising the study instruments), the inter-judge reliability ranged from .94 to 1.00 with some random error due to carelessness. On the open-ended items correlations ran from .87 to 1.00. Items which were differentially coded were examined, discussed, and if unresolvable a third opinion was sought. These cases were very rare. Given the checking procedures and the high level of agreement,

there is confidence that a minimum of error has been introduced by the coding procedures employed in this study.

With respect to internal reliability and validity of data collection procedures, one final area needs to be addressed. Several existing scales and indicators were used to measure major study variables, either in whole or in part. In the following pages, data are presented on the reliability and validity of the scales used in this study. Where scales were created by the principal investigator, their construction is described.

Validity and Reliability of the Jenkins Scale: Ethnic Orientation

The Jenkins Scale developed to identify the "ethnic agency" was used in this study to assess the ethnic orientation of the nursing homes.[1] In addition, the scale was phrased in attitudinal terms (i.e., "Do you feel it is important to . . ."') as an assessment of the ethnic orientation of the resident and the key family member. Congruence of ethnic orientation was operationalized as the agreement of facility and resident ethnic orientation or facility and family ethnic orientation.

Based on extensive interviews with agency directors as well as program observation in 52 non-traditional, primarily ethnic, child welfare agencies, Jenkins analyzed data on the components of culturally-relevant programming in the child welfare sector. An analysis of these data showed three statistically distinct factors which could collectively be taken as an index of ethnic programming. They were

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[1] Jenkins, op. cit.

"Culture" (i.e., the use of ethnic foods, arts, activities, etc., and preference for same); "Consciousness" (i.e., support of the ethnic group as a power based and support of a separate ethnic service delivery program), and "Matching" (i.e., matching of provider and consumer on the basis of ethnicity; employment of ethnic staff; ethnic representation at the administrative level, etc., and preference for same). Inter-item correlations for these three sub-factors showed a high degree of internal validity as evidenced by the obtained Cronbach alphas: "Culture Index": .847, "Consciousness Index": .735, and "Matching Index": .543.[1]

Although the agencies which comprised the sample on which the scale was based were all child welfare agencies, there were institutional settings among them. It seemed that the use of ethnic components in service delivery to older persons in institutional settings could be addressed with an adaptation of the instrument applied to children in institutional settings. In fact, the importance of cultural continuity may be even greater for the aged than for children, because of the time spent in the traditional culture.

Given the purpose for which this scale was developed, it seemed appropriate for use as an assessment of ethnic orientation for both facilities and individuals. The validity coefficients show it to be of good internal validity and reliability. The relative newness of the Jenkins scale means that the external validity (i.e., the broader applicability and usefulness of the scale with different populations and in different settings) is not yet well established, but will be

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[1]Jenkins, op. cit., p. 52.

forthcoming with future use of the scale in different studies, and its use in the present research may contribute to this end. The operational assessment of constructs such as "ethnic orientation," "ethnic commitment" and "culturally-relevant" service delivery have been very problematic for the social welfare field. There are very few scales which seek to assess these dimensions alone. The Jenkins scale is useful in this respect. As stated, "It distinguishes among ideological goals, policy, program, and membership, and points to the fact that these can exist independently of each other."[1]

Validity of Functional Health Status Rating Scale

The Functional Health Status Rating Scale included in the Staff Checklist (see Appendix D, p. 3) was developed from several sources. The items represent an assessment of physical health and the basic senses (i.e., general health, eyesight, hearing, speech, and appetite); an assessment of the activities of daily living (i.e., feeding self, toileting, dressing, grooming, and ambulation); and an assessment of mental health through an evaluation of items such as awareness of surroundings, sociability with others, control of emotions, self-esteem, general morale, judgment and recall.

These items were selected because of the frequency with which they are cited in traditionally used rating scales for the functional assessment of the elderly. With respect to the assessment of physical health status, the gerontologist Lawton has stated that:

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[1] Ibid., p. 63.

> There is no satisfactory global index of physical health. Health is a concept far too complex to be represented by a single number. Lawton, Ward and Yaffe analyzed statistically 52 separate measures of health, hoping to obtain a smaller number of indicators. Even with the use of factor analysis to reduce the number, eight to ten separate health factors remain. It was clear that the determination of health depends upon whether one questions the subject or the doctor, or it depends on available health records. The results of our factor analysis demonstrate clearly that no single index can properly represent an individual's health.[1]

In spite of the very real limitations in assessing health by a single index, there seemed to be some face validity in the assessment of sensory acuity. The items in the scale on the activities of daily living were taken from the "Physical Self-Maintenance Scale"[2] developed by Lawton and Brody. This scale has been widely used in geriatric practice as an assessment procedure. It should be noted, however, that a different coding procedure was used in this study to make the items commensurate with other assessment areas included in the Likert-type scale.

With respect to the "Emotional/Mental" rating scale, the areas included represent those traditionally assessed by clinicians in the mental assessment of geriatric patients. "Cognitive and intellectual activities such as memory, orientation, learning, judgment and comprehension are intimately dependent on the functioning of brain tissue. Defects in these intellectual abilities have long been considered as behavioral indications of brain impairment."[3] As with

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[1] M. Powell Lawton, "The Functional Assessment of Elderly People," Journal of the American Geriatrics Society, XIX: 6 (June 1971), p. 467.

[2] Ibid., p. 471.

[3] H. Shan Wang, M.D., "Evaluation of Brain Impairment," in Mental Illness in Later Life, ed. by E.W. Busse and E. Pfieffer (Washington, D.C.: American Psychological Association, 1973), p. 79.

the physical areas assessed, these items have some face validity, as well as a history of traditional use by practitioners and researchers in the field of aging.

Task Performance Index:
Validity of Operational Indicators

The task performance areas assessed by residents and family members as operational indicators of the concept "shared function" (e.g., food treats, shopping, gifts, phone calls, etc.) were taken from similar instruments in the Dobrof study. The ultimate aim is to have comparative data on the Black aged for areas of family performance evaluated in the Dobrof research. In her rationale for selection of these indicators, Dobrof stated that:

> The questionnaires for the study had to be designed in a way that would operationalize the theory of shared function and specify the activities of families which could be identified as indicators of their performance of familial tasks . . . Empirically, the tasks selected were those which in my own experience had been typically familial activities, and the final list was validated in discussion with administrators, social service directors, line staff and nursing personnel in other institutions.[1]

With respect to the use of frequency of visiting as an operational indicator of shared function, one could make a case for the face validity of this procedure. Much of the task performance takes place during visits, thus these two indicators are conceptually and empirically related. As Dobrof noted, " . . . visiting of the aged person may be regarded as the single most valid indicator of familial sharing . . . /it is/ a sign that institutionalization does not mean abandonment."[2]

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[1] Dobrof, op. cit., p. 284.

[2] Ibid., p. 363.

Satisfaction with Care Scale

The decision to assess satisfaction with care as a dependent variable in the study was made on the basis of what the Shared Function Thesis predicts about degree of family involvement and resident satisfaction with care: namely, that the family's extension of basic institutional provisions would lead to greater satisfaction with care (as evaluated by both the resident and the family).

How best to operationalize "satisfaction with care" proved problematic. Since this study sought to build on the Dobrof findings, an examination of her interview guides indicated that satisfaction with care had been assessed by an open-ended question which would produce a more qualitative response. She asked, for example, "On the whole, are you satisfied (dissatisfied) with the Resident/Patient living arrangements and the care which the institution provides (physical facilities, programs, food, quality and range of care, other Resident/Patients, financial arrangements, etc.), Specify."[1] In a related question, she asked: "On the whole, are you satisfied with the way the institution and its staff treat you and other family members?"[2] It seemed that these questions did not lend themselves to either a quantitative scaling procedure or a differential analysis for each aspect of care being assessed. However, the aspects of care specified in the questions (i.e., food, programs, staff attitudes, etc.) had face validity. It was decided to separate out the different aspects of care

[1] Dobrof, op. cit., p. 6 (Family Interview).

[2] Ibid., p. 7.

being evaluated and have the resident and family evaluate each in a Likert-type scale. Ten areas were specified for assessment: (1) physical surroundings (rooms, lounges, etc.), (2) quality of the medical and nursing care, (3) food, (4) social activities, (5) financial arrangements, (6) emotional support/counseling, (7) attitude of the staff/display of concern, (8) family involvement, (9) other resident (friendliness, similarity to self, etc.), and (10) accessibility of the staff and administrator. Each of these items was evaluated on a four point scale from "Very Satisfied to Very Dissatisfied." The cumulative ratings represent the resident's or family's "Satisfaction with Care" score. It was felt that this scoring procedure would increase the reliability of consumer ratings of care by (1) making sure that each consumer responded to the same set of items, and (2) making available a standardized closed set of response options which would make comparisons across respondents more feasible.

The obtained "Satisfa-tion with Care" score could be looked at in relation to several independent variables in the study. Mean or median scores could be compared between two or more groups representing different strata on significant independent variables. The scale also permitted comparisons of sub-group responses to different aspects of care, whereas a more global evaluation might not indicate where various aspects of care were differentially evaluated.

Havighurst Life Satisfaction Scale:
Resident Morale

A scale devised by Neugarten, Havighurst and Tobin[1] was employed in this study as one of the operational measures of resident morale. In describing their scale, the authors state that:

> Here the variables to be measured have been the individual's own evaluation of his present or past life, his satisfaction or his happiness. The assumptions are, whether or not explicitly stated, that the individual himself is the only proper judge of his well being; that the value judgments of the investigator can thus be minimized; and perhaps more important, that it is not appropriate to measure well-being in old age by the same standards that apply to middle age, namely standards based upon activity or social involvement.[2]

Scale items were originally isolated from data obtained in intensive repeat interviews with a panel of 177 persons, aged 50 to 70, of middle and working class backgrounds from the white population of metropolitan Kansas City. The chronically ill and physically impaired were excluded from the original panel, which could be a problem given the nature of the present study population.

Data obtained in the "formulative" interviews on that study focused on current life patterns of the elderly respondents, their values, and their attitudes about old age, illness, death, immortality and self-image. From the data so obtained, four assessment areas were identified as separate, but related factors in overall Life Satisfaction:

(1) Zest vs. apathy: Low ratings are given for being bored with most things, for feeling that one must force oneself to do things, and for meaningless (and unenjoyed) hyperactivity.

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[1] Bernice L. Neugarten, Robert J. Havighurst, and Sheldon S. Tobin, "The Measurement of Life Satisfaction," Journal of Gerontology, 16: 3 (April 1961), pp. 134-143.

[2] Ibid., p. 134.

(2) Resolution vs. fortitude: The extent to which the elderly person accepts personal responsibility for his life, accepts his life as meaningful and inevitable and is relatively unafraid of death--all result in higher ratings.

(3) Congruence between desired and achieved goals: Higher ratings given for the extent to which the older person feels he has achieved his goals in life, no matter what those goals may be; low ratings go to those who feel they have missed out on opportunities.

(4) Mood tone: High ratings for the older person who expresses happy, optimistic attitudes and mood and who expresses pleasure in life; low ratings for those expressing depression.[1]

Reliability and validity of the scale. In order to assess the reliability of the ratings produced by the scale, two independent judges rated each of the 177 subjects on the basis of data about their lives and attitudes obtained in the interviews. The coefficient of correlation was .78 and use of the Spearman-Brown coefficient of attenuation produced a correlation of .87.[2] Thus, the reliability of the scale was quite good.

The authors note that:

> The LSR depended on the scoring of judges who had read all of the recorded interview material, but who had not themselves interviewed the respondent. In seeking to establish an outside criterion by which these ratings could be validated, the investigators thought it desirable to have an experienced clinical psychologist interview the respondents and then make his own ratings of Life Satisfaction.[3]

A clinical psychologist rated 80 of the original 177 subjects on the basis of face-to-face interviews. The ratings of the clinical psychologist (i.e., the criterion) were correlated with the original

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[1] Ibid., pp. 137-138.

[2] Ibid., p. 139.

[3] Ibid.

ratings of these 80 subjects which produced a validity coefficient of .64.[1]

The validity of the Life Satisfaction Rating Scale appears to be good. Nevertheless, the validity of using the scale on a Black institutionalized population is still subject to question. Neither Blacks or frail elderly or substantial numbers of lower SES aged were included in the sample upon which the scale was constructed. However, several other findings cited in the researchers' discussion of the scale suggested that it may have broader applicability and could be used with a somewhat different aged population. Among these were:

(1) There was no correlation between Life Satisfaction Ratings and age of the subject (i.e., the more aged were not necessarily those with lower morale).

(2) There was no correlation between Life Satisfaction Ratings and sex of the respondent. Thus the disproportionate representation of females among the institutionalized aged would probably not be a source of bias.

(3) There was a positive, but very low correlation (.39) between Life Satisfaction ratings and the Index of Social Characteristics (based on residence, education and occupation). Thus, using the scale on residents who were predominantly of a different socioeconomic level would not necessarily produce biased results.

In addition to the ease of application and scoring of the scale, there was one other factor which made it seem suitable for use with this study's population. Upon examination of the validity coefficients

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[1] Ibid., p. 139.

for the scale, the authors found that the validity was substantially greater for the oldest persons in the panel. With respect to this finding, they note:

> It is of some interest in this connection that the correlation between LSR and LSR-Cl was higher for the older members of the sample. For 30 cases aged 70 and over, r was .70; for the 50 cases aged 69 and below, r was .53. It may be that the aged individual has less of a tendency to give conforming or "normative" responses in the regular interview situation than does the younger individual; thus providing fewer instances in which the clinical psychologist's depth questions revealed a different level of functioning than shown by the replies to the more structured interviews. It might be, on the other hand, that in some manner of which the investigators were unaware, they devised interview questions and rating scales for Life Satisfaction that are more appropriate for the very old respondent than for the somewhat younger respondent, and as a result, different judges were more likely to agree in their evaluations of persons over 70. Whatever the explanation, age differences such as these should be explored further in future studies.[1]

These five scales, along with necessary demographic data, formed the core content of the four data collection instruments developed for this study.

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[1] Ibid., p. 140.

CHAPTER V

DESCRIPTION OF RESIDENT AND FAMILY MEMBER RESPONDENTS

There were 93 Black aged residents interviewed in this research, and they comprise the "resident sample". The description of this group will be relevant to two of the major study questions: (1) What are the salient demographic characteristics of aged Blacks in nursing homes in New York City? and (2) How do these data compare to available information on elderly whites in nursing homes in New York City? In addition, the study sample will be looked at in relation to national norms for Blacks in nursing homes.

Table 5 presents data on the resident sample by age at interview, sex, place of birth, religion, education, and former occupation. With respect to age, 45 percent of the residents interviewed were 81 years or older, with a median age of 79 years. There were over twice the number of females relative to males, 70 percent and 30 percent respectively. Most of the residents were born in the Southern United States (63 percent) with about equal representation from the Northern states (17 percent) and the Carribean Islands (20 percent). With regard to the latter statistic, there were two islands which were more represented - Jamaica and Barbados. As expected, the vast majority of these aged residents are Protestants (88 percent) as are most Black aged. Also, as other studies have shown for the Black

TABLE 5

DEMOGRAPHIC PROFILE OF RESIDENT RESPONDENTS, BY AGE, SEX, PLACE OF BIRTH, RELIGION, EDUCATION, FORMER OCCUPATION

Variable	Categories	Percentage (N=93)
Age at Interview	55-60 Years	11
	61-70	15
	71-80	29
	81-90	33
	91-99	12
	TOTAL	100
Sex	Male	30
	Female	70
	TOTAL	100
Place of Birth	United States (North)	17
	United States (South)	63
	Carribean	20
	TOTAL	100
Religion	Protestant	88
	Catholic	12
	TOTAL	100
Education	1-6 Grade	50
	7-9	24
	10-12	4
	High school graduate	12
	Some College +	10
	TOTAL	100
Former Occupation	Professional/Managerial	6
	Sales	2
	Clerical	4
	Crafts/Skilled	7
	Operative	14
	Laborer	15
	Domestic Service	52
	TOTAL	100

elderly in general, they were poorly educated and have worked most of their lives in low status, unskilled occupations. The median year of schooling was 6th. Only 22 percent of the residents had graduated from high school, with 10 percent having had some college or higher education. With respect to occupation, 52 percent of the residents were formerly employed as domestic servants and most of these were women. The men were employed mainly as laborers and factory operatives. Overall, 81 percent of the residents had been in unskilled or semi-skilled occupations.

A cross-tabulation of major demographic variables was undertaken to determine patterns of interrelationship. Two factors emerged as important determinants of other demographic characteristics. These were age and sex of the resident. As Table 6 shows, age and sex distribution themselves appear to be related. Not unexpectedly, the males in nursing homes are younger than the females. Whereas 51 percent of the females in the sample were 81 years or older, only 32 percent of the males were this old. Male-female differentials in life expectancy and longevity probably account for this difference. The other interpretation which could be offered is that Black males enter nursing homes at younger ages than females.

There was an expected relationship between age and marital status. The data in Table 7 indicate that older residents were much more likely to be widowed than younger residents. Also of interest is the fact that five of the ten residents under the age of 61, were separated or divorced,

TABLE 6

RESIDENT SEX, BY AGE

Age	Male N	Male %	Female N	Female %
55-60 Years	5	18	5	8
61-70	7	25	7	11
71-80	7	25	20	31
81-90	7	25	24	37
91-99	2	7	9	14
TOTAL	28	100	65	100

two of the ten were never married and only one out of the ten was married. These findings are in agreement with the findings of others who have studied institutionalized populations. Lack of spouse is often cited as a major reason for admission to a nursing home. It appears that widowhood is responsible for lack of spouse among the older residents in this sample, most of whom had been married. For the younger resident, however, lack of spouse is a function of divorce, separation, and never having married.

TABLE 7

RESIDENT MARITAL STATUS, BY AGE

Age	Total	Never Married	Married	Widowed	Separated/ Divorced
55-60	10	2	1	2	5
61-70	14	6	2	4	2
71-80	27	7	2	17	1
81-90	31	2	3	23	2
91-99	11	1	-	10	-

Also, as would be expected, there was a relationship between age and education and age and occupation. In both cases older residents were less educated and more concentrated in low status jobs than younger residents. The data presented in Table 8 indicate that 16 of the 31 residents in the 81-90 age category received a 6th grade or lower education and the pattern was even more characteristic of the 91-99 cohort, where ten of the 11 residents received a 6th grade education or less. At the other end of the continuum, all of the ten residents in the 55-60 age cohort received a higher than 6th grade education, just four of the ten having had some college or more.

TABLE 8

RESIDENT EDUCATION, BY AGE

Age	Total	Grade 1-6	Grade 7-9	Grade 10 High School	Some College +
55-60	10	-	2	4	4
61-80	41	21	10	6	4
81-90	31	16	9	5	1
91-99	11	10	1	-	-

Occupation follows a similar pattern as the data in Table 9 show although the differences in the age cohorts are not as great as they were for educational attainment. In every age group except the youngest the majority of the residents were in domestic service or laboring jobs. The overall proportion, however, is less as one goes

down the age range. A comparison of the groups at opposite ends of the continuum will illustrate. Whereas eight of the 11 residents in the 91-99 age group were in domestic service or laboring jobs, this was true for only four of the ten residents 55-60 years of age.

TABLE 9

RESIDENT OCCUPATION, BY AGE

Age	Total	Laborer/ Domestic	Operative/ Skilled	Sales/ Clerical	Manager/ Professional
55-60	10	4	2	3	1
61-80	41	26	10	2	3
81-90	31	24	5	-	2
91-99	11	8	3	-	-

Sex of the resident proved to be a more important factor in availability of family, marital status, and closeness to family than did age of resident.

TABLE 10

RESIDENT MARITAL STATUS, BY SEX

Sex	Total		Never Married		Married		Widowed		Widowed/ Separated	
	N	%	N	%	N	%	N	%	N	%
Male	28	100	5	18	6	21	13	47	4	14
Female	65	100	13	20	2	3	43	66	7	11

The relationship between sex of the resident and marital status is examined in Table 10. The data show that the Black aged male residents were less likely to be widowed than the female residents and somewhat more likely to be still married. This pattern has been observed in other studies of institutionalized aged. It has been attributed to the younger ages of the males, which usually means availability of an even younger spouse. In this sample, also, males were a little more likely to be divorced or separated.

TABLE 11

AVAILABILITY OF FAMILY, BY SEX

Sex	Total		Family Available		Family Unavailable	
	N	%	N	%	N	%
Male	28	100	15	54	13	46
Female	65	100	49	75	16	25

Yates Chi-square = 5.17, df=1, p .05

With respect to availability of family, sex of the resident proved to be a significant factor. As the data in Table 11 show, only 54 percent of the males had any available family, whereas 75 percent of the females had family available. This difference was statistically significant at the .05 level. To the extent that availability of family is related to assurance of quality care and resident morale, male Black aged residents may be significantly disadvantaged relative to female residents. Even among the males who had families, their relationship

with them was not as good as it was for females and their families.

TABLE 12

CLOSENESS TO FAMILY, BY SEX

Sex	Total N	Total %	Not Close N	Not Close %	Close N	Close %
Male	15	100	7	47	8	53
Female	49	100	6	12	43	88

Yates Chi-square = 6.41, df=1, $p < .02$

Residents were asked to rate their relationship with family as either "very close", "somewhat close", "not too close" or "not close at all". The data presented in Table 12 show the relationship between these ratings and sex of the respondent. Ratings have been collapsed into "close" and "not close", and then cross-tabulated with sex. Males were significantly less likely than females to rate their relationship with family as "close", 53 percent compared to 88 percent for females. This difference suggest another hypothesis which might explain the admission of males to nursing homes at an earlier age. To the degree that availability of family and commitment of family as indicated by degree of closeness are factors affecting risk of institutionalization, Black aged males may be more at risk than females. The offsetting factor, may be the lower life expectancy of Black males relative to

females.

Data were also obtained on living arrangements prior to admission. These findings are presented in Table 13.

TABLE 13

LIVING ARRANGEMENTS PRIOR TO ADMISSION
BY RESIDENT REPORTS

Prior Living Arrangements	Percent (N=93)
In private home	82
Not in private home	18
TOTAL	100
Who resident lived with in the private home[a]	
Lived alone	46
With spouse only	19
Adult children	13
Siblings	5
Other relatives	9
Unrelated others	8
TOTAL	100
Where resided if not in private home	
Other LTC facility	47
General Hospital	35
Boarding Home	12
Hotel	6
TOTAL	100

[a]"Private Home" includes apartments shared by a family unit.

Most of the resident respondents (82 percent) lived in a private home. Of these, the modal category was "lived alone" 46 percent. Only 19 percent lived with spouse only and even fewer 13 percent lived with adult children. In regard to those residents who were not in private homes, 47 percent came to the nursing home from another long-term care facility, followed by those who were in a general short-stay hospital.

Reports from staff indicate that most of the residents were hospitalized just prior to admission. Indeed, certification for admission and Medicare funding for nursing home care usually require prior hospitalization and hospital or medical certification of need. It is clear, then, that most residents answered this question by specifying their living arrangements prior to the hospitalization which preceeded admission to the nursing home.

The resident sample can also be described in terms of physical health status and mental health status. Data on physical health status is presented in Table 14. Staff were asked to rate the resident respondents on ten areas related to sensory acuity and ability to perform the tasks of daily living. The findings presented in Table 14 indicate that residents were rated higher in most areas of sensory acuity, with the exception of eyesight, and rated much lower in their ability to perform the tasks of daily living, with the exception of ability to feed oneself. Over 50 percent of the residents were rated as "excellent or good" in ability to speak, appetite (which would probably be related to taste and smell), sleeping patterns and hearing. On the other hand less than half of the residents were rated

TABLE 14

SOCIAL SERVICE AND NURSING STAFF
EVALUATIONS OF RESIDENT PHYSICAL HEALTH
(N=93)

Area Evaluated	Excellent or Good Percent	Fair/Poor Percent
Ability to feed self	73	27
Speech	73	27
Appetite	68	32
Sleeping patterns	64	36
Hearing	50	50
Toileting	49	51
Grooming self	48	52
Dressing self	43	57
Eyesight	29	71
Ambulation	26	74

as "excellent or good" in ability to toilet alone, groom and dress alone or get around on their own. This profile coupled with the fact that most of these residents lived alone, help define why extended nursing care was needed.

Data on the evaluations of the mental status of the resident respondents are presented in Table 15. These data show that residents were rated higher on three of the eight areas assessed.

TABLE 15

SOCIAL SERVICE AND NURSING STAFF
EVALUATIONS OF RESIDENT MENTAL HEALTH
(N=93)

Area Evaluated	Excellent or Good Percent	Fair/Poor Percent
Awareness of surroundings	71	29
General Morale	70	30
Recall	67	33
Self-esteem	48	52
Judgment	39	61
Control of emotions	37	63
Sociability	36	64
Participation in activities	29	71

Seventy-one percent were rated as "excellent or good" in their awareness of their surroundings, 70 percent for good general morale, and 67 percent for good recall. This is in part, a function of the sampling strategy employed in the study. The residents interviewed were initially judged by staff as capable of being interviewed. They would, therefore, have a better sense of reality and recall than some other residents. They were not rated as well in self-esteem, judgment, control of emotions or sociability. Only 29 percent of the residents were rated "excellent or good" on participation in activities. During the interview some residents expressed dissatisfaction with social activities in the nursing home which they described as "childish". To the extent that activities are geared to the level of residents who exhibit symptoms of organic brain syndrome, residents who possess

greater command of their faculties may resist participation in activities which they feel demean them. As such, low participation may be a sign of mental health rather than mental disorder.

So far, the demographic profile of the resident sample has focused on detail about the sample itself or internal variations among sample sub-groups. It is important also to look at this sample in relation to data from other studies which describe Black aged in the community and in institutional settings. Such comparisons help to identity potential risk factors, as well as suggesting possible sample bias to the degree that this sample departs significantly from established norms.

Table 16 presents a comparative profile of the institutionalized respondents in this study and Black elderly respondents in a New York City Office on Aging survey[1] who lived in the community. The New York City Office on Aging undertook a survey of the elderly in New York City in 1972. Using a probability sampling design with a two-stage enumeration process, 2000 households in 26 neighborhoods were identified as having 1 or more occupants over the age of 60 years. From these households, 1,552 elderly persons were interviewed and 580 of them were Black. This study sample, therefore, provides data on the Black aged who reside in the community. Using the Office on Aging data as a comparative group, it may be possible to begin to identify ways in which the institutionalized Black aged are different from the Black aged still in the community.

[1]Cantor and Rosenthal, op. cit.

TABLE 16

PROFILE OF BLACK ELDERLY RESPONDENTS IN THE N.Y. CITY OFFICE OF AGING SURVEY AND THE STUDY SAMPLE, BY AGE, SEX, MARITAL STATUS RELIGION, OCCUPATION, EDUCATION AND LIVING ARRANGEMENTS

Characteristics	N.Y.C. Office On Aging Sample (N=580)	Study Sample (N=93)
Age		
60-70 years	58	24
71 and over	42	69
TOTAL	100	100
Sex		
Male	35	30
Female	65	70
TOTAL	100	100
Marital Status		
Married	29	8
Widowed	45	60
Never Married	11	20
Separated/Divorced	15	12
TOTAL	100	100
Religion		
Protestant	86	88
All other	14	12
TOTAL	100	100
Occupation		
Manual Occupations	79	81
All other	21	19
TOTAL	100	100
Education		
8th grade or less	65	74
9th grade or above	35	26
TOTAL	100	100
Living Arrangements[a]		
Alone	33	46
With spouse only	29	19
With others	38	35
TOTAL	100	100

[a]Living arrangements for the study sample refer to living arrangements prior to admission to the nursing home. Percentages are based on the 76 respondents out of the 93 who resided in private homes in the community.

The data in Table 16 indicate that the institutionalized respondents in this study were a little more disadvantaged educationally and occupationally. There were also slightly more females than males. Each of these however, can be attributed to age differences between the two groups. As shown, there was a substantial difference between the Black aged in the institution and in the community with respect to age. Whereas 58 percent of those in the community were 70 years or younger, this was true for only 24 percent of the institutionalized population--a difference which is statistically significant at the .01 level. This finding concurs with data from other studies on white aged in institutions (e.g., Brody, 1974; Zappolo, 1977). Thus, advanced age appears to be a risk factor for Blacks as it is for whites.

The groups also differed with respect to marital status. There were fewer married persons among the institutionalized Black aged and fewer divorced and separated persons. There were almost twice as many never married persons among the institutionalized group, and whereas 45 percent of Black aged in the community were widowed, 60 percent of the institutionalized Black aged were widowed ($p < .05$). Again, lack of spouse emerges as a possible risk factor. In addition, Never Married persons would be less likely to have children which would place this group at greater risk.

Finally, with respect to living arrangements, there were differences between the groups. There were more persons who formerly lived alone among the institutionalized group, 46 percent compared to 33 percent of the Black aged still in the community. The percentage

of those who lived with others was very similar for the two groups, 38 percent of the group in the community and 35 percent of the group in the institution. This pattern too is documented in the literature on the institutionalized population as a whole.

It would appear, that for Black aged, advanced age, lack of spouse, and solitary living are factors which placed an aged person at risk of institutionalization,as has been documented for white aged.

A further effort was made to determine the degree to which the respondents in this study differ from available data on Blacks in nursing homes on a national level. According to the 1973-74 National Nursing Home Survey,[1] there were 49,300 Blacks residing in licensed nursing homes. The data in Table 17 compare these Black nursing home residents to the residents in the study sample with respect to age, sex, and marital status. The data on prior living arrangements in the National Survey were not broken down by race.

As the data in Table 17 show, the residents who comprised this study sample appear to be eight years older on the average. However, the National Black mean reflects the inclusion of non-aged Blacks who also reside in nursing homes (i.e., 22 percent under the age of 55). Using data from the National Survey[2] and eliminating the 22 percent under age 55, the mean age rose to 76.3 years. Thus, there is not as much of an age differential: 2.4 years.

Finally, there is some evidence that Black residents who reside in predominantly Black nursing homes may be younger. The residents

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[1]Zappolo, op. cit.

[2]Ibid., Table 3, p. 22.

TABLE 17

DEMOGRAPHIC PROFILE OF BLACK NURSING HOME RESIDENTS IN THE NATIONAL NURSING HOME SURVEY AND THE STUDY SAMPLE, BY AGE AT INTERVIEW, SEX, AND MARITAL STATUS

	National N.H.[a] Survey Sample (N=49,300)	Study Sample (N=93)
Sex (Percentage)		
Male	39	30
Female	61	70
	100	100
Marital Status (Percentage)		
Married	11	8
Widowed	61	60
Divorced/Separated	8	12
Never Married	20	20
	100	100

[a]National statistics are from Characteristics, Social Contacts, and Activities of Nursing Home Residents: United States: 1973-74 National Nursing Home Survey, USDHEW: Public Health Service, HRA, DHEW Publication No. (HRA)77-1778.

in predominantly Black nursing homes in the study sample were compared to those in predominantly white nursing homes on all of the demographic variables. Only one variable was found to be significantly different for these two groups: age. The mean age for residents in predominantly Black nursing homes was 75.6 years, very close to the mean age of 76.3 for Black aged nursing home residents on a national level. The mean age for Black residents in the predominantly white nursing homes was

79.9. A difference which was significant at the .01 level. The reasons for this differential are not known.

With respect to marital status, the national sample and the study sample are similar, especially in regard to the two categories shown to be more related to institutionalization: widowed and never married.

Thus, with respect to age, sex distribution, and marital status, this study sample does not depart significantly from established national norms for Blacks in nursing homes.

One final comparison seems appropriate. Since this study is in part a replication of the Dobrof study and because comparisons will be made with findings from the Dobrof study on major study variables, it seemed important to compare this study sample to Dobrof's study sample. Table 18 compares the Dobrof sample to this sample on the three variables most often associated with admission to a nursing home: age, sex, and marital status.

As the data in Table 18 show, the white, predominantly Jewish sample in Dobrof's study were on the average four years older than the residents in this study, 82.8 years and 78.7 years respectively. This would suggest that Blacks enter nursing homes at younger ages than do white aged. However, the mean age for all persons in nursing homes on a national level, the majority of whom are white, was reported to be 79 years.[1] This would suggest that the Dobrof sample may be somewhat overrepresented by persons in the oldest age cohorts among the institutionalized aged. To the extent that differences between

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[1]Zappolo, op. cit., p. 3.

TABLE 18

DEMOGRAPHIC PROFILE OF NURSING HOME RESIDENTS IN THE DOBROF STUDY AND THE STUDY SAMPLE, BY AGE AT INTERVIEW, SEX, AND MARITAL STATUS

	Dobrof Study Sample (N=247)	Study Sample (N=93)
Sex	Percent	Percent
Male	28	30
Female	72	70
	100	100
Marital Status		
Married	6	8
Widowed	62	60
Divorced/Separated	11	12
Never Married	21	20
	100	100

residents in the Dobrof sample and residents in this study are found on other study variables which may also be related to age, this differential should be kept in mind.

Thus on two of the three key variables associated with admission to a nursing home, the Dobrof sample and this one are very similar. They do, however, differ with respect to age.

Description of the Family Member Respondents

As noted in the Methodology, 27 family members were interviewed. A number of family statuses were represented among the family respondents, with adult children predominant. The data presented in Table 19 provide more detail about the characteristics of these respondents.

As the data indicate, 74 percent of the family members were over the age of 51, with the modal age category being 61 and over. The calculated mean age was 55 years (s.d.=11). The age distribution of these respondents would suggest that the adult "children" of the aged residents are themselves involved in the aging process. The popular myth about young, vital and selfish children dumping their aged parents in nursing homes, does not fit the realities of this group of families.

With respect to sex distribution, 29 percent of the family respondents were males and 71 percent were females. The predominance of females among involved family members has been noted in other studies, including the Dobrof research. It will be recalled that the modal family status was daughters, followed by sons, sisters, and nieces in the same proportion. Two granddaughters were interviewed but no grandsons.

The generational advances in education and occupation are evident. Fifty-seven percent of these familiy members had completed high school, with 17 percent having had some college or more. These family members are not concentrated in domestic service and laboring jobs as the aged residents were. There is a greater spread across

TABLE 19

DEMOGRAPHIC PROFILE OF FAMILY MEMBER RESPONDENTS, BY AGE AT INTERVIEW, SEX, EDUCATION, OCCUPATION, INCOME, MARITAL STATUS AND SOCIAL CLASS POSITION

	Categories	Percentage (N=27)
Age at Interview	under 30	3
	30-40 years	10
	41-50	13
	51-60	30
	61 and older	44
		100
Sex	Male	29
	Female	71
Education	0-9 years	18
	10-12	25
	High school graduate	40
	Some college +	17
		100
Occupation	Professional, managerial	6
	Sales	7
	Clerical	16
	Crafts/skilled	7
	Laborer	10
	Domestic	19
	Retired	16
	Unemployed	19
		100
Annual Family Income	Under $5,000	21
	$5,001-$10,000	32
	$10,001-$15,000	21
	$15,001-$20,000	16
	$20,001 and over	10
		100
Marital Status	Married	30
	Widowed	40
	Divorced/Separated	10
	Never married	20
		100
Social Class[a]	Lower/poor	20
	Working class	44
	Lower middle	28
	Middle	8
		100

[a]Social class status is based on the Duncan 2-factor index of occupation and education. See Otis Dudley Duncan and Beverly Duncan. "Residential Distribution and Occupational Stratification," American Journal of Sociology, 60, 1955:493-503.

occupational categories. In the highest occupational level - professional and managerial, however, the proportional representation is nearly the same as it was for the aged residents. Thirty five percent of the family members were either retired or unemployed. Unfortunately, former occupation was not obtained for these individuals.

Fifty-three percent of the family members had annual family incomes of $10,00 or less. The median income was $9,250 which is slightly under the $9,800 median income figure for all Black families on a national basis for 1978.

The data on marital status indicate that the largest group among these family members were widows (40 percent),followed by married persons (30 percent), never married (20 percent) and divorced or separated (10 percent).

Finally, using the Ducan two-factor index of social class based on occupation and education, 64 percent of these family members were classified as working class or lower. The profile of the family respondents which emerges is of a predominantly female group, itself involved in the life events which accompany aging as evidenced by 40 percent in the widowed category. In terms of occupation, education and income they are not unlike other Blacks in their age cohort.

Caution should be exercised in generalizing from these study findings to all Black families with institutionalized aged members. The small number of family members in the study and the obvious self-selection which their cooperation in the research represents, should

be considered in interpreting these data.

In addition to family member demographics, family respondents were asked to provide some information on the rest of the family network, its size, and proximity to the nursing home. These are all structural features of the family which might affect the family's ability to participate in the care of an institutionalized aged member.

TABLE 20

SIZE OF THE FAMILY NETWORK AS REPORTED BY FAMILY MEMBERS

Reported Network Size	(N=27)
Very small (0-2 people)	9
Small (3-6 people)	11
Medium (7-10 people)	13
Medium-Large (11-15 people)	1
Large (15+)	3
TOTAL	27

The data presented in Tables 20 and 21 indicate family member responses to questions on the family network and its composition. The data show two predominant patterns. First, the networks are small for the most part. A third of the respondents were in family situations where they were the only surviving kin or where there were one or two other family members. Seventy-four percent (20 out of 27) family members were in family networks comprised of six or fewer other people.

This would suggest that lack of family resources in the form of personnel who could share the tasks associated with care of a frail aged member may be a factor in the decision to seek admission to the nursing home.

TABLE 21

RESIDENTS WITH KIN AVAILABLE AS REPORTED BY FAMILY MEMBERS, BY FAMILY STATUS AND NUMBER

Relationship to Resident	Number of Surviving Kin			
	None	One	Two	Three+
Daughter(s)	14	8	4	1
Son(s)	15	10	1	1
Grandchild(ren)	13	3	1	10
Sister(s)	14	3	7	3
Brother(s)	18	3	4	2
Spouse	26	1	-	-

The data in Table 21 relate to the second predominant pattern. Of the surviving kin, more were females. This might explain why females are more represented among involved family members. For example, the data show that more daughters were available relative to sons and more sisters were available relative to brothers.

The other aspect of availability is physical proximity. The data in Table 22 show that 26 of the 27 respondents indicated that someone in the family resided in New York City. Half of the family members reported that someone in the family lived near the nursing

home, 15 out of 27, and another 10 out of 27 reported that the aged resident had a close friend near the facility.

TABLE 22

PROXIMITY OF FAMILY AND FRIENDS AS REPORTED BY FAMILY MEMBERS

	(N=27)
Someone in family lives in N.Y.C.	26
Someone in family lives near the facility	15
Close friends live near the facility	10

Summary

From the demographic data obtained it appears that sex of the Black aged nursing home resident may be related to age at admission and reason for admission. The male residents in the study sample were younger than the female residents. They were also less likely to have family available. Where male residents had family they were less likely than female residents with family to feel close to family members. To the extent that family support mitigates risk of premature admission to a nursing home, Black aged males appear to be more at risk.

Data on physical health status of the residents indicate that they suffer most from the inability to perform the tasks of daily living such as grooming, dressing, and ability to get around on their own. This may also be related to reason for admission to the nursing home.

When compared to available data on Black aged still residing in the community for the study site, the residents in the study sample were significantly older and more likely to have never been married or to be widowed. This is the same pattern reported in studies which compare community-based and institutionalized white aged populations.

CHAPTER VI

ETHNIC FACTORS IN LONG-TERM CARE: THE INSTITUTIONAL EXPERIENCE FOR BLACK AGED

In this chapter, the nursing home experience for aged Blacks will be examined on several levels. First, factors identified by nursing home administrators as affecting access and utilization will be discussed. These responses are presented as background for the quantitative material. Since there were only five administrator interviews, the analysis necessitated the use of more qualitative data and case illustrations. Secondly, data will be presented on the decision-making process surrounding admission as reported by residents, staff and family members. Included here will be information on reasons for admission, referral sources, and selection of the facility. Finally, the importance of cultural factors in long-term care service delivery will be addressed as data on resident and family attitudes are presented.

Access and Utilization

From interviews with nursing home administrators of the five facilities in the study, four major reasons were identified as being responsible for the lower utilization of nursing homes by Black aged. These were (1) prevalence of cultural attitudes which are antithetical to the use of formal institutions to care for the aged, (2) discrimination in nursing home admission policies which favor patients who are

"more profitable", (3) limited long-term care resources within Black communities, and (4) problems of outreach and education to potential consumers within the Black community. There were variations among the five administrators on the relative importance of each of these factors.

With respect to cultural attitudes, the comments of two administrators illustrate the frequently cited negativism which Blacks feel toward the nursing home:

> Paramount behind the low utilization of nursing homes by Blacks is, in my opinion, an overwhelming cultural antipathy towards institutions of this genre. The majority of Blacks look upon the necessity of institutionalization as a combination of personal and family failure, and to the religious retribution for the sins of one's life. In many instances where the resident may in fact understand and accept the need for institutional placement, family members are resistant since they fear the censure of the community for having "put one's mother or father away". Family members often feel a terrible sense of shame. This is sometimes extended to church members who in many situations become, in fact, family to the patient.

> I think that there are more family members and neighbors who are <u>willing</u> and <u>able</u> to offer assistance in the Black community along with a strong value system which prescribes mutual aid and care of the aging.

For some administrators, however, there was a stronger belief that limited access has been a more important factor:

> It seems to me that in the past because of the extended family patterns among Blacks there was low utilization of nursing homes by elderly Blacks. Because of certain practices of discrimination in admission, Blacks did not have the same opportunity for admission as did whites. Nursing home placement seems to have become more acceptable to Blacks in recent years. Of course, the number of Blacks in nursing homes varies with each home and its geographical location. At the present time, we receive a great number of applications from elderly and not so elderly Blacks.

Another administrator stated that:

> Personally I don't feel a cultural value against the institution. I feel it is an issue of access which will change if there are more facilities within the Black community. There has been resistance to institutionalization by many Black people, but once we were opened we had little problem filling our beds and developing a rather long waiting list. There were many inquiries from families. The extended family network among Blacks is a myth. I say this based on my experience here in the past 10 years. There are substantial numbers of elderly Blacks who live alone. Very often, church members, and not family members, are the ones who help out.

Rather than being competing explanations, these factors probably operate simultaneously to affect decisions among Blacks about nursing home utilization. The comments of the fifth administrator probably illustrate the multi-faceted nature of the problem:

> I feel there is a need for nursing homes within the Black community. There is, however, in the Black community a feeling that the nursing home is a last resort, and people try to keep the elderly at home. For many people there comes a point where skilled nursing is needed and the family just cannot provide this type of care. In most Black families, the elderly have a position of power and respect. They don't want to see this go and neither do I.

Reasons for Placement

As the comments of some nursing home administrators illustrated, for many Black aged there comes a point when they are unable to manage in the community. In these cases, the family is unable to provide the level of intensive and ongoing care which is required. Further evidence of this is provided by resident and staff reports on reason for admission.

The data presented in Table 23 indicate that both staff and resident respondents gave priority to the inability to manage alone and

TABLE 23

REASONS FOR RESIDENT ADMISSION,
ACCORDING TO STAFF AND RESIDENTS
(Percentage Distribution)

Reason	Staff (N=93)	Resident (N=93)
Couldn't manage alone	80	72
Poor physical health	70	63
Family unable to continue care	43	22
Loss of mobility	40	38
Mental confusion	3	1
Loss of home/apartment	10	10
Fear of living alone	7	5
Fear of declining health	8	6
Loneliness	6	3
Financial need	-	-
Changing neighborhood	6	5
Death of spouse	3	7

poor physical health as the principal reasons for admission to the nursing home. It seems appropriate in this context to recall that data presented in Chapter V related to staff evaluations of resident physical health status. The residents were evaluated most negatively on ability to perform the tasks of daily living. This finding would support their admission for reasons related to inability to manage alone. The third most frequently cited reason was the family's inability to continue care, mentioned by staff for 43 percent of the residents and by 22 percent of the residents themselves. It is interesting that residents were less likely to cite this as a reason for admission as compared to staff. The difference is probably one of problem definition. In reality three

factors (i.e., poor physical health, inability to care for self, and inability of family to provide care) are all interrelated.

In an effort to determine if reasons for admission among Black aged were different from those of white aged, data on reasons for admission were compared for this study sample and the Dobrof sample.

TABLE 24

REASONS FOR RESIDENT ADMISSION IN DOBROF STUDY AND PRESENT STUDY, ACCORDING TO RESIDENTS (Percentage Distribution)

Reasons Specified	Dobrof Study[a] Respondents (N=247)	Resident Respondents (N=93)
Poor physical health	41	63***
Couldn't manage alone	14	72***
Family unable to care for	2	22***
Loss of home/apartment	4	10*
Fear of declining health	6	6
Death of spouse or other family caretaker	16	3***
Changing neighborhood	8	5
Loneliness	3	3
Financial need	2	-

[a]Dobrof, Care of the Aged: A Shared Function, op. cit., Table XIX, p. 598.

*p of obtained Chi-aquare is less than .05
**p of obtained Chi-square is less than .01
***p of obtained Chi-square is less than .001

As can be seen from the data presented in Table 24, the samples were compared on nine most frequently cited reasons for admission. Significant differences were found to exist for five of the nine reasons.

A significantly greater number of aged Blacks cited inability to manage and poor physical health as the main reasons for admission. One explanation is that aged Blacks enter nursing homes in much poorer physical condition. The literature cited previously on the health status of the Black aged would support such an hypothesis. One other explanation, however, needs to be examined. In recent years the requirements for certification of need have become more stringent and more health related. An examination of certification forms like the DMH 1 Form shows that areas of physical health, mental acuity, and the assessment of ability to perform the tasks of daily living are prominant. The five year period between the collection of the Dobrof data and the data collection for this study has been one of change in admission requirements and certification of need. These findings must be viewed in light of this change in policy.

Black aged in this study were also significantly more likely to cite "family unable to continue care" as a reason for placement than respondents in the Dobrof study. This may be due in whole or in part to the severity of health and management problems which precipitated placement. Related to this is the fact that working patterns in most Black families require women to be out of the home. Many residents mentioned voluntarily that their adult daughters had to work and were, therefore, unavailable to provide ongoing care. More Black aged mentioned "loss of home or apartment" as a reason for admission to the Home. The response of 88 year old Miss J. illustrates:

> Last winter I had a stroke and they took me to the hospital. While I was there I got dispossed. A friend of mine came to visit me at the hospital to tell me that my furniture and all my things were on the street. All I could do was cry. What could I do. I couldn't even move around so I couldn't do anything about it. I guess they thought I was dead. My friend was able to get a few of my clothes. But everything else I had was taken. I have nothing now but what you see in this room.

Miss J. had no family. She lived alone for several years prior to her stroke. Her situation vividly illustrates the vulnerability of aged Blacks who share these characteristics.

"Death of spouse or family caretaker" was sighted significantly less often by Black aged. It will be recalled that 62 percent of the Dobrof sample and 60 percent of the study sample were widowed. This finding, therefore,should not be viewed as a reflection of differential rates of widowhood, but rather a differential in defining the circumstance of widowhood as one which would necessitate nursing home placement.

Finally with respect to reason for admission,responses of the 27 family members interviewed and their aged relatives were compared in an effort to determine if families and residents defined the reason for admission differently.

Data on this comparison are presented in Table 25. Among the residents, poor physical health was the most frequently cited reason. Among the families, however, the most frequently cited reason was the family's inability to care for the aged relative. The sample size is very small and the selectivity of the family respondents has been noted,

TABLE 25

REASONS FOR ADMISSION, ACCORDING TO RESIDENTS AND FAMILY MEMBERS

Reason	Resident Response (N=27)	Family Response (N=27)
Couldn't manage alone	14	12
Poor physical health	22	18
Family unable to continue care	14	25
Loss of mobility	5	3
Mental confusion	1	1
Loss of home/apartment	2	2
Fear of living alone	2	2
Other	4	3

however, the difference in problem definition observed for this group of aged Blacks and their families is interesting. It suggests several things. First as one of the nursing home administrators noted, many Black families feel deeply about their inability to care for their aged members. The family members, therefore may be placing greater emphasis on what they perceive to be a failure in filial responsibility rather than on the severity of the physical and management problems of the aged relative. The residents appear more often to define the problem as one of poor health and the inability to manage alone. For the aged relative, it may also be less painful to define the problem as one of physical illness rather than the family's inability to provide care which could be seen as abandonment.

Referral and Decision-Making

TABLE 26

PERSONS WHO HELPED THE RESIDENT DECIDE TO SEEK ADMISSION AS REPORTED BY RESIDENTS

Source of help	Residents (N=93) Percent
Family	21
Hospital staff (SS/Nurse)	30
Friends	8
Professional and Family	7
Physician	7
Social Service Agency	3
Homemaker/Home Help	3
Minister/Priest	3
Made Decision Alone	10
Transfer from another nursing home	8
TOTAL	100.0
Total with professional assistance	53 percent

Residents were asked who helped them make the decision to seek admission to the nursing home. Their responses are presented in Table 26. As the data show, the modal response was hospital staff (both social service and nursing staff). Given the predominance of health related factors in reasons for placement and the nature of the certification process, this finding is not unexpected. The next most frequently cited source of help was the family. In all, 53 percent of the residents had some professional assistance in making the decision to enter the nursing home. Only 10 percent stated that they made the decision alone.

TABLE 27

PERSONS WHO HELPED TO MAKE THE DECISION TO SEEK ADMISSION: COMPARISON OF THE RESIDENT AND FAMILY RESPONSE

Source of help[a]	Resident Response (N=27)	Family Response (N=27)
Family	18	10
Hospital staff	9	13
Physician	3	6
Minister	1	1

[a]More than one source of help could be specified, therefore, totals will not add up to 27.

When responses of family members and the residents were compared on this question, an interesting difference was observed. The data in Table 27 indicate that the residents were more likely to indicate the family as the main source of assistance in decision-making, while families placed greater emphasis on the role of medical professionals. This could be explained by differences between residents and family members in both knowledge and perception of the actual decision making process. For example a very ill aged parent in a hospital bed may not be aware of the fact that the son or daughter has received help from the hospital staff in exploring the nursing home as an alternative. When the adult child then communicates with the aged parent about the possibility of placement, the parent may perceive the family as the major source of decision-making. Data on referral source are presented

TABLE 28

REFERRAL SOURCE AS REPORTED BY STAFF AND RESIDENTS
(Percentage Distribution)

Referral Source	Staff Response	Resident Response
	(N=93)	(N=93)
Hospital staff	49	39
Family	16	23
Social service agency	7	4
Churches	7	--
Friends	3	6
Staff member at the nursing home	2	--
Home help aid	--	4
Advertisement	--	--
Other	--	3
Transfer from another nursing home	9	11
Not ascertainable	6	10
TOTAL	100	100

in Table 28. The data show that medical professionals also played a key role as referral sources. When the staff and residents were asked who referred the aged person to the nursing home, the modal response from both sources was hospital staff. Staff indicated that 49 percent of the residents were referred to the nursing home by hospital staff. Thirty-nine percent of the residents said they were referred by hospital staff. This ten percent differential probably reflects the same difference in knowledge and perception of the decision-making process as noted previously between residents and family members. Such an interpretation would be supported by the fact that residents were more

likely than staff to cite the family as the referral source, 23 percent and 16 percent, respectively--an eight percent differential.

Finally on the question of referral, a comparison of resident and family responses as presented in Table 29 supports previous research findings on the important role which medical personnel play in referral to nursing homes.

TABLE 29

REFERRAL SOURCE AS REPORTED BY RESIDENTS AND FAMILY MEMBERS

Referral Source	Resident Response	Family Response
	(N=27)	(N=27)
Hospital staff/medical	10	18
Family	10	3
Friends	3	2
Advertisement	2	1
Other	2	3

Again, the pattern of resident perception of the family's role as more important than hospital staff is observed. The family response, however, indicates that hospital staff were most important to them as a referral source.

Another aspect of the decision-making process which was examined was the exploration of alternatives to the nursing home. Staff and resident responses to this question appear in Table 30.

The staff response is quite different from the resident response and probably reflects the fact that staff are not always aware of

TABLE 30

PERCENTAGE OF RESIDENTS WHO CONSIDERED ALTERNATIVES PRIOR TO ADMISSION, AS REPORTED BY STAFF, RESIDENTS

Alternative Considered	Staff	Residents
	(N=93)	(N=93)
Yes	19	82
No	43	22
Don't know	38	6
TOTAL	100	100

consideration of alternatives prior to the formal application for admission. Staff did not know for 38 percent of the residents whether or not alternatives had been considered. If one feels the exploration of alternatives is part of the admission intake process, this is a disturbing finding.

In cases where they did have knowledge of this area, staff reported that most residents did not consider alternatives to the nursing home. Staff reported that 43 percent of the residents did not consider alternatives, whereas only 19 percent did so. The fact that alternatives were not considered becomes even more apparent when resident responses are examined. Eighty-two percent of the residents reported that alternatives were not considered. This question was also asked of family members whose responses concurred with those of residents and staff. Twenty of the 27 family members reported that alternatives to the nursing home were not considered. Several hypotheses

could be put forth to explain this pattern. The first is that the physical health problems and management problems were so severe that the nursing home seemed the only option. This might especially be the case for residents without available family or caring resources of any kind.

Another possible explanation is a lack of knowledge, information and/or referral to other kinds of formal services which may have been of assistance such as adult day care, homemaker and home help assistance, meals-on-wheels, etc. Whatever the explanation, this finding has both practice and policy implications which will be addressed in detail in Chapter VIII.

Related to this, residents were asked to identify the alternatives considered and to explain why alternatives were given up in favor of the nursing home. In answer to the first question, 11 residents who did consider alternatives indicated that staying with an adult child or other member of the family was the most often considered alternative (N=7), followed by employment of a homemaker (N=3) and moving in with a friend (N=1). For most of the first group, the necessity for both adults in the household to be employed full-time made this an unworkable solution. Adult daughters could not afford to give up working to take care of an ailing parent, even with the support of an employed spouse. The three residents who had considered home help had bad experiences with this service when it was tried. The following response from a 97-year-old female amputee illustrates:

> When I came home after my operation, I had a homemaker that the social worker in the hospital arranged for me. But I didn't work out. Sometimes I would be three or four days without service. The social worker felt I would be better off in a nursing home.

The final area explored in the decision-making process was the selection of the nursing home. Related to this was the question of whether or not those contemplating admission "shopped around" for the nursing home which they felt best suited their needs. For the most part, the answer was no. Eighty-eight percent of the residents stated that no other nursing homes were visited by them or members of their families prior to admission. Of the 27 family members interviewed, 19 reported that they had not visited other nursing homes. It was revealed in the administrator interview that several of the nursing homes had affiliations with specific hospitals. Under these circumstances, perhaps potential consumers and/or their families are not advised to shop around. This should not, however, be viewed as a factor which would necessarily lead to resident dissatisfaction with the facility selected. Over half of the aged residents (52 percent) indicated that there was something in particular which they liked about the nursing home which influenced their decision to seek admission. These data are presented in Table 31.

The feature of the nursing home which residents liked the most was the physical plant of the facility: its rooms, lounges, decor, etc. Equally cited by 15 percent of those residents responding to the question was the fact that the facility was recommended by a respected professional and that the facility was church sponsored. Another ten percent of the 49 residents responding to this question liked the nursing home because it was near their church, three percent because it was close to family and three percent because it was close to their neighborhoods. Although these percentages are not great, this response suggests that the location of the nursing home is an important factor

TABLE 31

WHAT IN PARTICULAR WAS LIKED ABOUT THE FACILITY AS A FACTOR IN THE DECISION TO SEEK ADMISSION, AS REPORTED BY RESIDENTS (Percentage Distribution)

What in Particular Was Liked	Residents (N=49)
Physical facilities	33
Recommended by a respected professional	15
Church sponsorship	15
Good reputation	--
Close to church	10
Close to family	3
Recommended by friend	8
Family member on staff	5
More Black residents	3
Friends in the nursing home	3
Advertisement	3
Close to neighborhood	3

for some residents in the decision to seek admission. For these residents, being near accustomed surroundings was an important consideration.

Thus far, the discussion had focused on factors leading up to admission. Attention is now turned to level of resident satisfaction with the decision to enter the nursing home. Staff and residents were asked to evaluate resident acceptance of the decision to enter the facility. Their responses appear in Table 32.

According to these data, most residents accepted the decision well. Sixty-six percent of the residents reported that they accepted the decision well. Only 15 percent of the residents reported opposition

TABLE 32

RESIDENT ACCEPTANCE OF THE ADMISSION DECISION, ACCORDING TO STAFF AND RESIDENTS (Percentage Distribution)

Level of Acceptance	Staff (N=93)	Residents (N=93)
Accepted entry well	43	66
Resigned, but not accepting	18	--
Opposed	22	15
No reaction expressed	7	--
Don't know/not ascertainable	10	19
TOTAL	100	100

to the admission. Although staff also reported that most residents were accepting of the decision, they did not present the same picture as the residents did. According to staff reports, only 43 percent of the residents were accepting of the decision, another 18 percent were resigned to it, while 22 percent were opposed and another seven percent expressed no reaction. This difference could be explained by either staff misinterpretation of resident reaction or selective resident recall which may serve a protective function. Part of the process of accepting the admission and adjusting to life in the nursing home may be a repression of negative feelings about the placement. Some residents, therefore, may not recall (or wish to discuss) negative feelings.

For many residents, acceptance of the decision came with the recognition of how much they needed a protected environment. Take the case of Mrs. M., a widow, 79 years old. She and her husband came to the nursing home together. He died just a few months before she was

interviewed. Of the decision, she explained:

> I didn't want to come because I didn't want to give up my home. The social worker came to see me and she helped me to see that it would be better for me and my husband to live here because of all the things I was having difficulty doing.

Or, for example, the case of 69-year-old Mrs. C. This lady had lived with an adult daughter who tried to care for her while working full-time. When she came to the nursing home, she was severely underweight and in poor physical condition. At the time of the interview, she was robust and in good spirits. She expressed her feelings about the decision in the following way:

> I am so much better than I was when I came here. It has been very good for my physically. I could not have made a better decision. I should have done it much sooner.

For residents without any family and no other means of support, the nursing home can often be a refuge from a life of constant struggle to obtain the basic necessities for survival. A good illustration of this is Miss H. A soft spoken diminutive lady of 87 years, Miss H. worked in domestic service until her health began to fail. She resides in a nursing home sponsored by her church. When she was asked, "What do you think about your decision to come here to live?" she replied:

> I don't have to think about it. I have good food and clothing. Here's my wash basin and I have my own toilet. I have always had to use the bathroom way down the hall. It's an ideal place to live. I even have my own heat and I can turn it up or down to suit myself. The Lord intended me to be here so I can enjoy the rest of my life in these beautiful surroundings.

Another female resident whose family would not aid her when she was very ill, answered simply, "Coming here was the right thing to do. If I had stayed outside, I would be dead by now."

For some residents, however, the opposition to the placement was

still keenly felt. Mrs. L., for example, is 74 years old and blind. Before a brief stay in the hospital she had managed her own household, and quite well, she thought. She felt her family made the decision without considering her feelings. Of this she said,

> It was the most terrible thing that I had ever heard. That my children could say this to me. They did away with my furniture and everything. Why? I was doing fine in my home.

Or take for example the case of Mr. W. A 68-year-old widower, Mr. W. came to reside in the health-related facility of a large geriatric center. His grandniece and nephew, his only surviving relatives, insisted that he come. Of this demand he said:

> I see no reason to be here. My grandniece and nephew feared for me because I lived alone after my wife died. I was not afraid. How could I be afraid among my friends and neighbors? I didn't come here. I was brought here. What am I doing way up here in the Bronx when I was born and raised in Brooklyn? I objected and I still object. I hate them for it. I hate them to this very day.

In addition to those who accepted the decision and to those who opposed it, is a third group and in some ways these are the saddest cases. These are the residents who feel they played no part in the decision, but were institutionalized because of indifference. A poignant illustration, is the case of Mr. G., a 60-year-old West Indian immigrant. During the interview, he reported:

> I am separated from my wife--oh, for many years. I have a boy, but I never see him. I was in an accident and lost both of my legs. When I was in the hospital, the doctor told me I was coming here. The doctor said to me, "You can either go to the poor house or to the nursing home." So I came here.

Family members exhibited the same range of reactions to the decision to place their aged relatives. Staff members were asked to recall the family's reaction to the decision at the time of admission.

They reported that of the 64 family members, 54 percent accepted the decision very well, 26 percent were resigned but not very accepting of it, 15 percent were opposed, and the feelings of the other five percent were not known. Like the aged residents, most were accepting of the decision, according to staff reports. When the 27 family members who were interviewed were asked how they felt about the decision, 24 replied that they felt it was the right thing to do and the other three were not sure.

A 60-year-old sister of a 69-year-old resident said of the decision:

> Yes, I know it was the right thing to do. She was mugged three times and was hit and kicked in the face. Her health was really declining before she went into the hospital. She is much better off here.

The daughter of another resident explained:

> It was an unexpected emergency. I was going into the hospital for an operation and mother had to go some place. She could not stay alone. She also needed medical attention and when I went into the hospital, they took her to the hospital, too. After she was somewhat better, the social worker recommended that I bring her here.

Among the family members, too, the situation of the lone aged person was raised. Although Mr. B. had a family, he was never part of it. When his sister was interviewed, she expressed her opinion on the decision in the following way:

> He thinks of this place as his home and I suppose it is. He's happier now than he was on the outside. In fact, he is as happy now as I have ever seen him as an adult. See, my brother is a loner. He was always a loner. He never married, never had any children. He never really had a place he could call his own. He has never been close to any of us in the family.

It is interesting to note of Mr. B. that the friendship networks which he developed in the nursing home were extensive and many staff

members commented upon this fact. On the day of the interview, Mr. B. was seated in the hallway outside of his room. Several of the other male residents had formed a line of chairs on either side of him. They were engaged in a lively conversation with much joking and laughter.

One final illustration. The case of Mr. M., a man of 80 years, who had suffered a stroke. His story is an interesting one because it exemplifies the case where the family objected to the placement and the resident desired it. His daughter explained:

> My father wanted to come here because his lady friend was coming here to live and he wanted to be with her. I was very hurt and disappointed at his decision because I could have taken care of him. I took a three week course at Harlem Hospital to learn how to care for him after his stroke. My father's lady friend had had a stroke herself. There was no way that I could have taken care of them both and my father accused me of trying to keep them apart. He was very unhappy when she decided to live in the nursing home. He asked for her constantly. We could not console him. My husband and I discussed it, and we finally agreed that he should come to live here if that is what he really wanted.

What each of these cases illustrates is that the nursing home experience is different for each aged person. For some, it is a welcomed alternative to a solitary and precarious existence in the community. For others, it is perceived to be a devastating experience of rejection and abandonment by the family. For still others, it represents the consequences of powerlessness where others are free to make major decisions without considering their feelings. Each case needs to be individualized and the appropriateness of the nursing home judged in relation to individual needs of the aged person.

Ethnic and Cultural Factors in Service Delivery

In addition to individual needs, there are also needs of the institutionalized Black aged which are related to their membership in a specific cultural group. As noted in Chapter II, current research has suggested that particular attention needs to be given to the inclusion of cultural components in service delivery to this population. Among these components are recognition of cultural patterns and preferences related to food, social activities, and grooming. Also important to some is the presence of others "like themselves" among the staff providing care. Jenkins has suggested that any service delivery system or institution can be evaluated in terms of its attention to the ethnic and cultural needs of its clientele. Those which make a conscious effort to insure inclusion of cultural components in the design of programs can be viewed as "ethnic agencies." There are specific indicators one can use to define the "ethnic agency." Once defined, the ethnic agency can be compared to non-ethnic agencies which in many instances also seek to deliver service to minority clients. Such a comparison would provide data on the relationship between cultural relevance in programming, client utilization of service, and client satisfaction with service.

Using this framework, three research questions were formulated. First, are long-term care services being delivered in ways which are culturally congruent with the predominant cultural patterns of Black aged? If so, what cultural components are included in service delivery? Secondly, how does the ethnic orientation of the nursing home affect the nature of service delivery? And third, how much importance

do Black aged residents and their families place on the inclusion of cultural components in service delivery? Data relevant to each one of these questions were collected in this research study. Attention is now turned to a discussion of study findings which relate to these questions.

Identification of the Ethnic Nursing Home

As the sampling strategy of this study suggested, an effort was made to compare nursing homes which served a majority of Black aged and those where aged Blacks comprised a small percentage of the client population. In order to assess the validity of whether this sampling strategy differentiated the nursing homes on level of ethnic commitment in service delivery, the scale developed by Jenkins to operationalize the concept of the "Ethnic Agency" was applied. Each of the facilities was examined and compared to the other nursing homes in the study sample, and the comparative profile is presented in Table 31.

There were nine (9) areas assessed. A score of 2 points was given for each affirmative response from the nursing home administrator in describing his program. As the data in Table 33 indicate, Facilities I and II had the highest ethnic commitment scores. These are the nursing homes identified by consultants as representative of the small Black nursing home. Facility III is the more complex nursing home which serves a 60 percent Black population. Its ethnic commitment score was also high. Facilities IV and V are the predominantly white facilities and although they may have an ethnic orientation which addressed the cultural preferences of other ethnic groups, their

TABLE 33

PROFILE OF THE PARTICIPATING NURSING HOMES ON FACTORS WHICH IDENTIFY THE ETHNIC AGENCY AS MEASURED BY THE JENKINS ETHNIC AGENCY SCALE

Ethnic Factor	Nursing Homes in the Study				
	I	II	III	IV	V
Facility administrator is Black	No	Yes	Yes	No	No
Facility has Blacks on its professional staff	Yes	Yes	Yes	Yes	Yes
Black staff participate in program planning	Yes	Yes	Yes	Yes	Yes
Black Southern and/or Carribean foods are served fairly regularly	Yes	Yes	No	No	No
Black cultural content is included in programs and recreational activities	Yes	Yes	Yes	Yes	No
Facility celebrates holidays which are important to Black residents	Yes	Yes	Yes	Yes	No
Facility has church services which allow Black residents to worship in their accustomed manner	Yes	Yes	Yes	No	No
Facility makes an effort to sensitive staff to the special needs and values of Black residents	Yes	Yes	Yes	Yes	Yes
Facility has Black representation on its Board of Directors	Yes	Yes	Yes	No	Yes
Ethnic Commitment Score for the Facility	16	18	16	10	6

scores were not high on attention to the cultural needs of their Black aged clients.

These patterns can be examined in more detail to see where the differences and similarities are. All five nursing homes have Blacks on the professional staff and all administrators stated that Black staff participated in planning and designing programs for the residents. The original scoring plan developed by Jenkins allowed for variation in scoring depending on the proportional representation of Blacks or minorities on the staff and the degree of their involvement in planning. However, this specific information was unattainable from some administrators who refused to answer these specific questions. Consequently, a much cruder scoring procedure is used in this analysis. If anything, these scores understate the differences in level of ethnic commitment as between "ethnic" and "non-ethnic" nursing homes. There was one other factor which all of the homes reportedly addressed. Each claimed to have made efforts to sensitize staff to the special needs and values of Black residents. The specific ways in which this was done were hard to ascertain. In one facility, there was once a formal seminar in which ethnic differences of residents were discussed. In another nursing home, the administrator pointed to the discussion of "case presentations" in which Black residents were the subject as staff sensitization. Because specifics were so difficult to obtain, the administrators' subjective definition of "sensitizing" was accepted with no attempt to validate these responses with objective indicators.

Four of the nursing homes celebrated holidays which they felt were important to Black residents. When asked for examples, the administrators usually cited the traditional American holidays like

Christmas, Thanksgiving and Easter which are indeed important to most Black aged because of their religious significance. In this instance dominant cultural patterns and patterns of the ethnic group happen to mesh. This requirement, therefore, could be met without any conscious effort to address cultural preferences of Blacks in residence.

There were several areas of ethnic programming which the Black nursing homes shared and which differentiated them more clearly from the white homes. Two of the three had a Black administrator. All of the Black nursing homes had Black representation on the Board as did one of the white nursing homes. Although administrators would not provide specific figures, the Boards of the Black nursing homes were predominantly Black. The nursing homes under Black administration were also more likely to serve ethnic foods on a regular basis, to include Black cultural content in music, art, and dance, and to provide church services which allowed Black residents to worship in their accustomed manner. These are some of the components which make them "ethnic" in their orientation.

As noted previously, many minority professionals and consumers of service feel that minority representation at the policy-making level is necessary if the special needs of the minority clients are to be adequately addressed. There is some empirical support for this view when the attitudes of the administrators are examined. Each of the administrators was asked to indicate how important they felt it was to address ethnic factors in service delivery. The questions were asked with specific reference to the needs of the Black resident. The responses of four of the five administrators appear in Table 34. The Administrator of Facility V did not respond.

TABLE 34

ADMINISTRATOR ATTITUDES ON THE IMPORTANCE OF ETHNIC FACTORS IN SERVICE DELIVERY AS MEASURED BY THE JENKINS ETHNIC COMMITMENT SCALE

Jenkins Scale Item	Facility Administrator Feels the Factor is Important in Programming				
	I	II	III	IV	V
Important for Facility Administrator to be Black	No	Yes	Yes	No	--
Important to have Blacks on the professional staff	Yes	Yes	Yes	Yes	--
Important to have Black staff participate in program planning	Yes	Yes	Yes	Yes	--
Important to serve Black ethnic foods on a regular basis to Black residents	Yes	Yes	Yes	No	--
Important to make efforts to include Black cultural content in programs/activities	Yes	Yes	Yes	Yes	--
Important to celebrate holidays which are important to Black residents	Yes	Yes	Yes	Yes	--
Important to have church services which allow Black residents to worship in an accustomed style	Yes	Yes	Yes	No	--
Important to sensitize staff to the cultural values and special needs of Black residents	Yes	Yes	Yes	Yes	--
Important to have Black representation on the Board of the Facility	Yes	Yes	Yes	No	--
Supports the establishment of separate Black nursing homes run and staffed by Blacks for their own aged	Yes	Yes	Yes	No	--
<u>The nursing home should</u>:					
(0) Treat all alike regardless of race or cultural background	X			X	
(3) Treat all people well, but recognize differences in ethnic background as it affects need and preferences for care					
(6) Actively sustain and/or promote pride of residents in their cultural/ethnic background		X	X		
Calculated Ethnic Commitment Score of the Administrator as it relates to Black Cultural Patterns	18	26	26	10	--

Administrator attitudes tended to conform to their programming practices as they were described in Table 33. There was across the board agreement on the importance of having Blacks on the professional staff and for these staff members to participate in program planning. There was also agreement on the importance of celebrating holidays important to Black residents and including cultural components in social and recreational activities.

On the importance of Black input at the administrative level, however, there were differences between the Black and white administrators. Both Black administrators felt it was important for the nursing home to have a Black administrator and for the Board to have Black representation. In addition, both supported the establishment of separate Black nursing homes. The white administrator in the predominantly Black nursing home took a mixed position. He favored Black representation on the Board and he supported the establishment of separate Black nursing homes. He did not, however, feel that it was important for the administrator of the nursing home to be Black. The white administrator of the white nursing home answered "unimportant" to each of these three areas. In effect, each of the administrators was affirming his or her own reality relative to the manner in which their facilities were organized and operated.

The administrators of facilities which served a greater percentage of Blacks were more likely to place importance on the regular provision of ethnic foods and culturally relevant church services, regardless of the race of the administrator. In this regard, these three facilities exemplify Litwak and Dono's conceptualization of the ethnic institution as one which attempts to extend primary group demand

for non-instrumentality to large numbers of people.[1]

The other major difference between Black and white administrators was in their ideology concerning delivery of service. Both of the white administrators felt that all residents should be treated alike regardless of race or cultural background. Both Black administrators took a position at the other end of the ideological continuum by feeling that they should actively sustain and promote the resident's pride in his cultural and ethnic background. When Ethnic Commitment scores were calculated by giving 2 points for each "yes" response on the importance of items in the scale, plus additional points as indicated on the ideological continuum, the scores of the two Black administrators were the same and the highest. The white administrator in the predominantly Black nursing home was in the middle in terms of his attitudes, and the white administrator in the white nursing home was the least committed to incorporation of ethnic factors in service delivery as they pertain to aged Blacks.

There appears to be a direct relationship between attitudes and practice, but the direction of causality is not so clear. In this 'thicken and egg" dilemma, it is not known whether the administrator's attitudes conform to the practice or whether practice is shaped by the attitudes. On another level, other factors, like consumer demand, might outweigh any ideological position as in the case of the administrator of Facility I. Although he subscribed to a "color blind" position ideologically, the services which his nursing home delivered were geared for the most part to the special needs of the minority group from which he drew his clientele. A deeper exploration of

[1] Litwak and Dono, op. cit.

patterns of consumer preferences may help to put these findings into perspective. Such an exploration should address the third question on the importance of ethnic factors to the consumers of service.

The Importance of Ethnic Factors to Consumers

Both the aged residents and, where possible, their families were asked to indicate their attitudes on the mixing vs. matching, cultural content, and power/decision-making items of the Jenkins Ethnic Commitment Scale. These data could then be compared to the ethnic profile of the nursing home in which the respondent resided, as an operational measure of congruence vs. incongruence in ethnic orientation as between the consumer and provider of service. The aged residents' responses are presented in Table 35 for the entire sample, and comparatively for residents in ethnic vs. non-ethnic nursing homes.

As the data in Table 35 show, taken as a whole, the sample of residents placed greater importance on the inclusion of cultural components in programming than on matching of staff and residents on the basis of ethnicity. There was substantial agreement on the importance of celebrating holidays, inclusion of church services which allow worship in the accustomed manner, the regular provision of ethnic foods, staff training to increase awareness of Black culture, and the provision of transportation to a church of choice when "appropriate" services are not provided within the nursing home. When the sample was divided by ethnic orientation of the host facility, no significant differences were found between the responses of residents in the two types of facilities on the cultural content items. On four of the six

TABLE 35

RESIDENT RESPONSE TO THE JENKINS ETHNIC COMMITMENT SCALE, BY ETHNIC ORIENTATION OF THE HOST FACILITY (Percentage Distribution)

Ethnic Factor	Total Sample (N=93)	Residents in Ethnic Nursing Home (N=72)	Residents in Non-Ethnic Nursing Home (N=21)	P of Yates Chi-square
Cultural Content Items:				
Celebration of holidays	90	90	86	NS
Provision of church services in accustomed manner	86	86	86	NS
Serve ethnic foods on fairly regular basis	77	77	75	NS
Black music, arts in activities	77	78	71	NS
Staff should be taught about Black culture	68	68	67	NS
Transportation provided to church of choice	68	71	52	NS
Mixing and Matching:				
Black staff involved in designing programs	58	62	45	NS
Black staff employed at all levels	48	55	29	.069
Administrator of the Home should be Black	27	33	7	.025
Decision-Making/Power:				
Black representation on Board of Directors	71	71	71	NS
Support separate Black nursing homes	50	57	24	.037
Overall Ideology:				
Equal treatment	70	67	81	NS
Pluralism	25	28	14	
Ethnic pride	5	5	5	
Mean Scale Score	16.5	17.1	14.5	t=1.566, df=91 NS
Standard Deviation	6.5	6.5	6.4	

items, residents in ethnic homes took a slightly stronger position, and on a fifth--the issues of transportation to a church of choice--residents in the ethnic nursing homes took a considerably more favorable position although the difference was not statistically significant. During the interview, residents most often commented spontaneously on the quality and preparation of food. Two responses illustrate that one cannot make assumptions about consumer preference. For example, an 83-year-old female resident in Facility IV stated:

> The food here is very bad. I am accustomed to food that is well seasoned and cooked well. I was so glad to go to my daughter's house over the weekend because my daughter has such good food.

On the other extreme, a 72-year-old male resident in Facility II which serves ethnic foods on a regular basis said:

> Sometimes you get tired of it. If I ever leave here, I will never eat collard greens again.

On the issue of matching staff and residents on the basis of ethnicity, the sample as a whole took a less favorable position. The strongest support was for the involvement of Black staff in designing programs (58 percent), followed by employment of Black staff at all levels (48 percent) and importance of the administrator's being Black (27 percent). When residents in ethnic vs. non-ethnic nursing homes were compared, the ones in ethnic nursing homes took a stronger position on each of the matching items. Sixty-two percent of residents in ethnic nursing homes favored involvement of Black staff in planning programs for the home, as compared to 45 percent of residents in non-ethnic nursing homes. On the issues of employment of Black staff at all levels, 55 percent of residents in ethnic nursing homes as compared to only 29 percent of residents in non-ethnic homes felt this was

important. The difference approaches significance at the .05 level. The greatest difference between the two was observed on importance of the administrator being of the same race. Although this ethnic factor was not strongly supported in either group, residents in ethnic homes were more likely to feel this was important (33 percent) as compared to only seven percent of residents in non-ethnic nursing homes ($p < .025$). The reasons which residents gave for their responses are interesting. They indicate that aged residents may take a similar position with respect to the importance of ethnic factors, but for different reasons. Responses on the importance of having Black staff will serve to illustrate. Many residents felt that Black staff understand their needs better:

> Because they understand our people better.

> Yes, I like to see my people in charge. They treat you better and cooperate with you more.

> The interest they have in old people is really what's important. But I do feel that our people know each other better--we know each other's troubles. It is necessary for us to take care of each other and I am glad they got together and built this place for the old people.

Others took this position because of a sense of fairness in providing employment opportunities for Blacks in the health professions:

> Our people have as much right to work here as anyone else. Anyway, we have more Black people here, so it makes sense.

Finally, for others, it was an expression of distrust and anger at the white world:

> It is very important to have colored people on the staff. I don't believe in the white man. I don't want whites here. White people can take care of their own. I don't want whites sleeping with me.

Residents who were not in favor of matching on ethnicity also took this position for varied reasons. The most typical reasons

related to associations of ethnic matching with racial segregation. The Southern backgrounds of most of these aged residents probably played a part in shaping their attitudes on this question. The following response illustrates:

> I believe the staff should be mixed. No segregation. one of the main problems in this work is segregation.

Related to this integrationist position was a larger world view, a humanist perspective rather than an ethnic perspective to which some residents subscribed:

> It doesn't matter to me what color they are as long as they have feeling. See race and color don't matter to me. My grandmother was Irish and my grandfather was Indian. I am Black and proud of it. I am not a race person. Humanity is what matters to me.

And for others, the presence of white staff in administrative and direct care positions was associated with a better quality of service:

> If you can get into an integrated facility, why not?
>
> I want a white social worker because Blacks don't know what they are doing.

The same kind of varied thinking led to differences in position on one of the two power and decision-making items. There was overall high support for the representation of Blacks on the Board of Directors and residents in ethnic and non-ethnic nursing homes expressed the same level of agreement (71 percent). For most of the residents in ethnic nursing homes, this reflects a consistent pattern of support for a stronger ethnic position. For residents in the non-ethnic nursing homes, their position is more difficult to understand. Specifically, why would there be such strong support for ethnic representation on the Board (71 percent) but such weak support for ethnic representation at administrative staff levels as indicated by the meager seven percent

support for a Black administrator. Two possible and related explanations come to mind. First there was some evidence that Black residents in predominantly white nursing homes answered these questions in relation to the reality of their situation. For example, positions of non-support for the stronger ethnic position were sometimes qualified by comments like, "They probably don't want to do these things," or "I would like to have these things, but there are too few Negroes here for that to happen." Perhaps under such circumstances the best that could be hoped for is that representation of Blacks on the Board will increase the likelihood of white staff and administrators being sensitized to the needs of their small Black population. Influence and persuasion are well established survival mechanisms used by groups in powerless positions.

On the question of separate Black nursing homes, the sample overall was split 50-50 on this issue. Comparatively, however, Black residents in ethnic nursing homes took a position of stronger support (57 percent) vs. only 24 percent of Black residents in white nursing homes who took this position ($p < .05$).

Finally, with respect to ideological position, most of these aged Black residents subscribe to the integrationist ideology that all people should be treated equally regardless of race or color (70 percent). This finding was not unexpected given the history of racial discrimination for this group of aged Blacks. Although the difference was not significant, residents in ethnic nursing homes were somewhat more likely to subscribe to a pluralistic ideology which places importance on the recognition of differences in service delivery--28 percent compared to 14 percent of residents in non-ethnic nursing homes.

There was a small minority position in both groups supporting the position of promoting ethnic pride, five percent in each group and the study sample overall. Thus, most of the resident consumers in Black nursing homes take a different ideological position to that of the administrators of their nursing homes. As the data show, however, agreement between provider and consumer of service is greater on the importance of attention to ethnic factors in actual service delivery. This can be seen even more clearly where resident attitudes are measured for each individual nursing home. Data comparing degree of ethnic commitment for the population in each facility appear in Table 36.

TABLE 36

MEAN RESIDENT ETHNIC COMMITMENT SCORES, BY FACILITY

	N	Mean Score	Standard Deviation
Overall Score	93	16.5	6.5
Ethnic Homes:			
Facility I	19	17.2	6.5
Facility II	31	17.8	6.7
Facility III	22	16.0	6.5
Non-Ethnic Homes:			
Facility IV	18	14.3	6.9
Facility V	3	12.2	1.2

As can be seen from the data in Table 36, residents, in the nursing home with the highest Ethnic Agency Score, Facility II (See Table 33, have the highest mean score on the Jenkins Ethnic Commitment Scale. The residents in Facilities IV and V which had the lowest Ethnic Agency Scores have the lowest mean scores on the Jenkins Ethnic Commitment Scale. A t-test for difference of means was done for Facility II and Facility IV (Facility V was not compared because of the very small n). The obtained t value was 1.708, df=47, $p < .05$ for a one-tail test.

The same explanatory dilemma exists for resident attitudes as it did for administrator attitudes. What is the causal direction? Do residents who have a strong ethnic commitment select facilities which exhibit a greater attention to the incorporation of ethnic factors in service delivery? (i.e., is there a self-selection process) Or do attitudes conform to the reality of the service delivery pattern within the nursing home?

Previously cited data on the decision-making process would suggest that Black aged residents do not "select" the nursing home. Very few residents or family members reported visiting other nursing homes prior to admission. Also, none of the 49 residents who specified something they liked about the nursing home in particular cited culturally relevant service delivery as a factor. These findings would suggest that attitudes flow from the realities of the living situation. On the other hand, hospital staff may make nursing home referrals on the basis of assumed or assessed resident preference for

patterns of care. Since this aspect of the decision-making process was not explored in this study, no empirical evidence or the dynamics of this process can be offered. However, it is an area which warrants further study.

Family Responses to the Jenkins Ethnic Commitment Scale

The 27 family members who were interviewed were also asked to express their attitudes on the importance of ethnic factors in service delivery. Their responses appear in Table 37.

As the data indicate, there was overall high agreement on the importance of cultural content in designing programs for the residents. There was strong support for training staff as a means of educating them about Black culture. There was also strong support for the regular provision of ethnic foods, celebration of holidays, use of Black music and art in activities, and provision of church services in the accustomed manner. On the last issues, families of residents in ethnic nursing homes took a somewhat stronger position on the importance of this aspect of service. There were, however, no significant differences between families of residents in ethnic nursing homes and families of residents in non-ethnic nursing homes on any of the cultural content items as tested by the Fishers Exact Test. The comments of the son of an 80-year old woman in Facility V illustrate the sentiments which many family members expressed:

> I have spoken to the administrator several times about the food they serve and the type of social activities. I feel at her age she should have some of the things that she likes. I am glad to say that he was very responsive to my requests.

TABLE 37

FAMILY MEMBERS' RESPONSE TO THE JENKINS ETHNIC COMMITMENT SCALE BY ETHNIC ORIENTATION OF THE HOST FACILITY

Ethnic Factor	Total Sample	Families in Ethnic Nursing Homes	Families in Non-Ethnic Nursing Homes
	(N=27)	(N=19)	(N=8)
Cultural Content Items:			
Staff taught about Black culture	23	17	6
Serve ethnic foods on fairly regular basis	21	14	7
Celebration of holidays	20	14	6
Black music, arts in activities	19	14	5
Provision of church services in accustomed manner	18	14	4
Mixing Matching Items:			
Black staff involved in designing programs	20	14	6
Black staff employed at all levels	17	11	6
Administrator of the home should be Black	5	5	-
Decision-Making/Power:			
Black representation on Board of Directors	19	15	4
Support separate Black nursing homes	12	10	4
Overall Ideology:			
Equal treatment	16	12	4
Pluralism	11	7	4
Mean Scale Score	14.4	14.8	14.1
Standard Deviation	7.3	7.6	7.6

On the matching items, family members were weaker in their support for the ethnic position. They were most likely to favor involvement of Black staff in designing programs, followed by employment of Black staff at all levels, and least supportive of the importance of the administrator's being Black. With respect to the latter, only five family members felt this was important and they had relatives in the ethnic nursing homes. Like the residents, some family members felt that they and their aged relatives would be better understood by Black staff:

> It makes it like home for Black people--like brothers and sisters, not professionals. Black people can relate better to the "tantrums" we have.
>
> You can talk to the Black administrator better and feel more at home with the staff. They are your people.
>
> Since the majority are Black here, there should be mostly Black staff.

There were, however, family members who did not place a great deal of importance on ethnic matching. The strongest statements against this policy occurred where family members felt the racial factor might outweigh the importance of professional competence. The comments of the 24 year old granddaughter of a resident illustrate:

> I don't give a damn about color. I want good care for her and some of the staff here don't care. Blacks should be hired if they are competent.

On the decision-making and power items, there was more family support for the representation of Blacks on the Board of the nursing home than for separate Black nursing homes. Families of residents in ethnic nursing homes took a stronger ethnic position on both of

items than did families of residents in non-ethnic nursing homes. None of these differences were statistically significant, however. Interestingly, there was stronger support for the integrationist ideology among families in ethnic nursing homes, while families in non-ethnic homes were split equally between the intergrationist position and the ideology of cultural pluralism. No family members endorsed the "ethnic pride" position. As the mean Ethnic Commitment Scores for the two groups show, there was no overall difference in the degree of ethnic commitment between families of residents in ethnic nursing homes and those of residents in non-ethnic nursing homes.

Because of the small sample size of the family member respondents, these findings should be interpreted with great caution. The highly self-selective nature of this group may introduce biases which account, in part, for reported attitudes. The question of family-facility congruence in ethnic orientation will be examined more closely in Chapter VIII where the relationship of this variable to Shared Function will be examined.

Problems for Blacks in Nursing Homes

One final area which should be addressed in a discussion of Blacks in nursing homes is the identification of any special problems which they have. When this question was asked of administrators, residents and family members, a variety of responses were given which indicate a broad range of problems. It was difficult to assess in many cases how many residents were actually affected by these problems.

In general the problems can be broken down into three categories which are not necessarily mutually exclusive. These include, problems for aged Blacks in nursing homes which are problems for any aged person in nursing homes. Secondly, problems which are related to previous life circumstances and the cumulative effects of poverty. And finally, problems which occur because of racial differences among residents in mixed facilities.

In the first category, several residents mentioned stealing as a problem. This was also reported by a few family members. One lady sadly explained that her daughter had made her a Mothers Day dress which she brought to the Home about a week before Mothers Day Sunday. When the resident went to get her dress it had been taken from her closet. Complaints to staff brought varied responses including the possible explanation that it had been lost in the laundry, although it had never been worn. This incident was so upsetting to her that she was unable to really enjoy the Mothers Day visit with her family.

Three residents mentioned their dissatisfaction with the age restrictions on visitors. They would have liked for their younger grandchildren to be permitted to visit them.

Finally, in this area an issue was raised which has been of long standing debate in the field of gerontology: mixing vs. segregating residents who are less well physically and mentally. This was mentioned in particular by family members. Residents appeared to be much more tolerant--even helpful to their roommates who were senile. The daughter of a 75 year old resident explained the problem this way:

> Aged and feeble people of sound mind should be put in separate facilities from those who are invalids, senile and chronically ill. It is unfair to them to have to share the same facility with severely impaired people when they have the ability to move around and do things for themselves. I am sure that this has adverse effects upon them which may not be readily seen. Constant proximity to sicker people can be depressing.

In the second category, administrators were more likely than residents to be aware, or at least to report, the kinds of problems which aged Blacks bring to the institution. Most are related to the problems of the aged Black population as outlined in Chapter II. For example, Blacks apparently enter the nursing home with many more medical and health-related problems. One administrator reported:

> The Black residents require a great deal more medical attention. Because of the type of occupations which they have had and the conditions under which they have lived, they enter with an enhanced degenerative medical status in comparison to other groups who were of a higher socio-economic status and enjoyed a better standard of living.

Two of the administrators mentioned the need for more mental health services and emotional counseling:

> Social service problems are the biggest problems. There is a great need for mental health services and emotional care. Our residents are from lower class backgrounds and this makes for many problems which came about while they were living in the community. They come with the cumulative effects of these problems. They just need more of everything.

> Black aged are accustomed to living with their families. Trauma and psychiatric problems are prevalent because of loss of family contact.

Finally previous life patterns also affect the types of activities which Black aged will participate in within the nursing home. One administrator explained:

> The Black aged require a lot more specialized care in the institutional setting because of lack of education and leisure time which affected their ability to develop hobbies and other leisure time activities. There is a resistance to group activities.

In the third category, residents in facilities which were racially mixed were asked if they had any difficulty related to the staff or the white residents in the nursing home. The majority had few problems to report. A few expressed some problems and feelings of isolation. A few examples will illustrate:

> You'd think that some of these white staff were born in the South.

One 73 year old female resident who was in a facility with a large Eastern European population, stated her feelings this way:

> I am the only Negro at my dinner table. I don't associate much with people. I don't understand the Jewish language so I cannot join in the conversation at the dinner table. I go to the dining hall to eat my meals and then I go back to my room.

Another resident in the same facility stated that:

> Sometimes they- you know, the foreigners will not sit next to you or if you sit down next to them they will get up and move. But that doesn't bother me, what bothers me is that there is too much foreign language spoken here.

Most of the Black residents in these racially mixed settings indicated that they are coping very well with any situation which does arise. One female resident described her situation this way:

> They don't bother me. I can take care of myself. If they don't want to associate with me, I don't want to bother with them. I will tell you something, My best friend

> here is a white lady. She has been a constant friend and companion. She goes to the dining hall with me every day and she does a variety of chores for me. We care very much about each other.

One spry little man of 89 related similar incidents to some of those just mentioned. In explaining why he was not bothered by them, he simply stated: "It's O.K. because I speak up for my rights and I don't take a crap."

Summary

The findings from this study on reason for admission support the findings of previous studies which indicate that poor health and the resulting inability for self-care are the primary reasons for institutionalization. There is some evidence that these reasons may be more important for Black than for white institutionalized aged. Another finding related to admission, was the importance of the role of hospital and medical professionals in the decision-making process. These professionals appear to be instrumental in helping the older person and/or his family make the decision to seek admission to the nursing home, and in making referrals to specific facilities. Also, both residents and family members reported that in most cases alternatives to the nursing home were not explored prior to seeking admission. The reasons for this lack of exploration were not obtained. Finally, with respect to acceptance of the decision once made, the majority of aged residents and families accepted the decision well. This appeared to be related to recognition of the need for skilled

nursing care given the degree of physical impairment among the aged in the study sample.

With respect to ethnic factors in service delivery, there was overall agreement among residents, family members, and administrators on the importance of cultural components in service delivery. These included the celebration of holidays important to Black aged, use of ethnic foods, use of Black music, arts and dance in social activities, etc. There was, however, much greater variation on the question of matching residents and staff on the basis of ethnicity. Black residents in Black nursing homes were more likely than those in white nursing homes to feel that ethnic matching was important.

Thus there appears to be a relationship between the ethnic orientation of the host facility and consumer attitudes on the importance of ethnic factors in service delivery. The direction of causality is not so clear, and it is difficult to determine if consumer attitudes are shaped by the nature of the service delivered or if service delivery changes in response to consumer attitudes and demand.

CHAPTER VII

THE SHARED FUNCTION THESIS: ITS APPLICABILITY TO THE BLACK INSTITUTIONALIZED AGED

In addition to providing a demographic profile of Black aged in nursing homes and looking at the importance of ethnic factors in service delivery to this population, the third purpose of this study was to answer a series of questions about the role of Black families within the institution. Specifically, data were collected to answer the following questions:

1. How available are families to Black aged in nursing homes?
2. If available, how do Black families work with the nursing home to assure the best care possible for their aged members?
3. Does Black family involvement manifest itself as a function of outreach to staff, attendance at special programs, level of visiting, and task performance as has been shown to be the case for other families with institutionalized aged members?
4. What are the differences between white and Black families in patterns of family involvement?

These questions will be answered by an analysis of data collected on patterns of family and friend visiting and task performance within the nursing home. In addition, several hypotheses will be tested which look at the relationship between ethnic factors and shared function, as well as the effects of shared function on resident satisfaction with care and resident morale. This discussion begins

with an overall assessment of the two major aspects of shared function: degree of visiting and extent of family task performance.

Patterns of Visiting by Family and Friends

According to reports of residents, 90 percent of them received visits and for 73 percent of the residents these visits were at least on a weekly basis. The first question is how this compares to established norms. In her report on the National Nursing Home Survey 1973-74, Zappolo stated that:

> The frequency of visitors is related to the resident's age, sex, race or ethnicity and marital status. Older persons, females, whites (excluding Spanish-Americans) and married persons received visitors more frequently than younger persons, males, persons of other racial and ethnic groups or those who were not married at the time of the survey.[1]

In this document, it was reported that on a national level, 88 percent of the nursing home residents received visitors, and 61 percent received visitors at least once a week.[2] The level of visiting for the study sample, then, is above the established national norms. Since it was reported that non-whites received fewer visitors, this should make the difference between the study sample and the national Black institutionalized population even greater. Comparative data on degree and patterns of visiting for these two groups appear in Table 38. As the data indicate, 80 percent of the institutionalized Black aged on a national level received visitors as compared to 90 percent of the study sample. Several explanations could be offered for this

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[1] Zappolo, op. cit., p. 11.

[2] Ibid.

TABLE 38

VISITING OF BLACK RESIDENTS IN THE NATIONAL SURVEY AND THE STUDY SAMPLE, BY FREQUENCY AND SAMPLE (PERCENTAGE DISTRIBUTION)

Degree of Visiting	National[a] Sample (N=49,300)	Study Sample (N=93)
	%	%
Receives Visitors	80	90
Frequency of Visits[c]		
Daily	6	5
Weekly	43	73
Monthly	16	8
Several times a year	13	4
Receives no visits	19	10
TOTAL	97[b]	100

[a]Source: National Nursing Home Survey, op. cit., Table 9, p. 30.

[b]The following footnote accompanied the table: "NOTE: Numbers and percents may not add to totals due to rounding."

[c]Chi-square=28.91, df=4, $p < .001$.

difference. The first is bias in the study sample. Because a random sampling procedure could not be used throughout the sampling design, there could be an overrepresentation of persons who receive more visits. Also, exclusion of very confused or unresponsive residents may explain this. The other possible explanation is that the national Black sample does include non-aged Blacks who are in nursing homes. As the

report noted visiting is related to age. Unfortunately the study report does not examine visiting patterns in relation to age and race simultaneously. It is possible that if aged Blacks in nursing homes were looked at separately from non-aged Blacks in nursing homes, the level of visiting would rise proportionately. Compared to all nursing home residents, however, the level of visiting for the study sample is not too disparate: 88 percent and 90 percent respectively.

These findings contradict the stereotype of the nursing home patient as one who rarely has contact with family and friends. This is even more evident when the frequency of visiting is examined. In comparing the national Black nursing home sample and the study sample, it can be seen that about the same percentage of residents received daily visits--six percent and five percent respectively. However, significantly more residents in the study sample received weekly visits, 43 percent of the national sample compared to 73 percent of the study sample ($p < .001$). The same explanations offered for overall degree of visiting may be applicable here. Again the patterns for the study sample are closer to the norms for the entire nursing home population, 73 percent of the study sample had weekly visits compared to 63 percent of the total sample in the National Nursing Home Survey.

A third possible explanation is that the National Survey underestimated the degree of visiting for Black residents in nursing homes. In this regard, the Wershow findings on errors in national based nursing home data are recalled.

Visiting patterns for the study sample were also compared to the Dobrof findings. Table 39 presents comparative data.

TABLE 39

COMPARATIVE DATA ON DEGREE OF VISITING FOR RESIDENTS IN THE DOBROF STUDY AND THE STUDY SAMPLE, BY DEGREE OF VISITING AND SAMPLE (Percentage Distribution)

Degree of Visiting[a]	Dobrof (NYC) Sample (N=247)	Study Sample (N=93)
Receives Visitors	75	90
Frequency of Visits[b]		
Monthly or more	70	86
Less than monthly	13	4
Receives no visits	17	10
TOTAL	100	100

[a] Chi-square=10.68, df=1, $p < .01$.

[b] Chi-square=7.42, df=2, $p < .05$.

Both the overall degree of visiting and the frequency of visiting were significantly greater for the Black residents in the study sample than for the residents in the Dobrof sample which was predominantly white. Seventy-five percent of the residents in the Dobrof sample received visitors compared to 90 percent of the study sample ($p < .01$). With respect to frequency of visiting 70 percent of the Dobrof sample received visits at least on a monthly basis compared to 86 percent of the study sample ($p < .05$).

Thus relative to Black nursing home patients on a national level and to a comparative group of white institutionalized aged for the

study site, the Black aged residents in this study are significantly advantaged with respect to visits from family and friends.

Who are the visitors? As will be recalled from Chapter V, 68 percent of the residents in the study sample had family available. Data collected in this study indicate that many residents also receive a considerable amount of visiting from friends, church members and volunteers in lieu of or in addition to visits from family. Data on who visits and how often as reported by residents are presented in Table 40.

TABLE 40

FAMILY AND FRIEND PATTERNS OF VISITING AS REPORTED BY RESIDENTS, BY RELATIONSHIP TO RESIDENT AND FREQUENCY OF VISITING (Percentage Distribution)

Relationship to Resident	Status Available	Frequency of Visiting				
		Weekly+	Monthly	Less	Never	Unknown
Spouse[a]	12	55	27	9	9	--
Daughter(s)	33	52	16	13	19	--
Son(s)	31	48	14	7	31	--
Grandchild(ren)	29	37	26	19	18	--
Sister(s)	24	23	32	23	22	--
Brother(s)	22	15	10	45	30	--
Other relatives	42	39	34	17	10	--
Non-Family Visitors:						
Friends	75	27	36	20	4	13
Church members or volunteers	44	52	15	--	--	33

[a]Only eight percent of the sample designated their marital status as "married." An additional four percent of the sample who were "separated" reported visits from their spouses.

As the data show, several family statuses were represented among those who visit, as well as friends, church members and volunteers. Twelve percent of the residents had a spouse available. Data on frequency of visiting indicate that the spouse was more likely to visit weekly or more often than other family members. This finding is in agreement with those of other studies on institutionalized populations. Daughters were available for 33 percent of the residents and these daughters were next highest in visiting on a weekly basis or more often. Although sons were about equally as available as daughters (31 percent), they visited less often and had the highest percentage of those who never visit (31 percent). Visiting from grandchildren and siblings was in the moderate range with more visits taking place monthly or a little less frequently. The greater involvement of female relatives is supported by data in Table 40 which show that daughters visit more often than sons and sisters visit more often than brothers. The greatest percentage of relatives who never visit were to be found among sons and brothers, 31 percent and 30 percent respectively. An examination of the "status available" column supports the reports of family members as reported in Chapter V on the smallness of the family networks. Given the small percentages of residents who have sons, daughters, sisters, etc., it is clear that in order for 68 percent of the sample to have "some family," the family members are sparsely spread across these statuses. Thus residents are probably not likely to have sons, and daughters and siblings, but rather a son and no daughters, or a sister, but no brothers, etc.

There were more friends than family available to these aged Black residents. Seventy-five percent of the residents reported having

friends and 96 percent of these friends were said to visit them. Friends were not as likely to visit as often as family members. For example, only 27 percent of friends were said to visit weekly or more, which is less than spouse, daughters, and some sons. The visiting pattern for friends approaches more the pattern for siblings. To the extent that physical health and mobility play a role in ability to visit, this finding is not unexpected. Both friends and siblings of the residents are likely to be in the same age cohort as the residents (or within a few years), thus they are likely to be suffering from some of the problems associated with aging which may make visiting problematic.

Forty-four percent of the residents reported visits from church members or volunteers. In the Black nursing homes, especially, volunteers are often from churches in the community. The importance of friends and church members to residents was reported by one administrator who stated during the interview:

> Although many of our residents do not have families, many have regular visits from friends. It is common for church groups to come to visit, to have prayer meetings or to have their members sing. There are also many visits from senior citizens clubs. Most of our residents at least have visits from friends.

Residents were asked to identify who the "other" relatives were who visited. Twenty-eight residents mentioned specific persons in the family. Those most frequently identified were nieces (18), nephews (5), mothers (2) and mentioned by one resident each were a girlfriend, "godchild," daughter-in-law, son-in-law, and great grandchild.

Sixty-seven percent of the residents with family knew of problems which made it difficult for family members to visit regularly. The major reason was poor health of the family member, followed by

distance between the home and the facility--here, both time and cost of travel were a problem, long or odd working hours were mentioned by a few residents, and two mentioned other family responsibilities. Data previously cited indicate that in spite of these difficulties, the families of nursing home residents included in the study sample visit regularly and for the most part, often.

TABLE 41

FRIEND VISITING PATTERNS AS REPORTED BY RESIDENTS WITHOUT FAMILY, BY RELATIONSHIP TO RESIDENT AND FREQUENCY OF VISITING
(Frequency Distribution)
(N = 29)

Relationship to Resident	Frequency of Visiting			
	Weekly+	Monthly	Less Often	Never/ Has None
One or two special friends	10	8	6	3
Volunteers	8	2	-	19
Church members	6	3	1	19
Many friends	2	2	1	24
Former neighbors	--	1	3	25

It seemed important to look at visiting patterns for those residents who did not have any family. Data for this group are presented in Table 41. The data indicate that relative to residents with family this group is disadvantaged with respect to range of persons available to visit and the frequency with which they are visited. Of the 29 residents without family, 26 (89 percent) had visits from one or two close friends. Of these 26 close friends, ten visited weekly or more. Beyond one or two close friends, however, few of these residents

reported visits from others. Only ten (about a third) reported visits from volunteers and church members. Few of these residents had visits from many friends or visits from former neighbors.

Thus, for residents without family, it is likely that most of their visits are from one or two especially close friends who may act as functional kin.

TABLE 42

FAMILY VISITING PATTERNS AS REPORTED BY FAMILY MEMBERS, BY RELATIONSHIP TO RESIDENT AND FREQUENCY OF VISITING (Frequency Distribution)

Relationship to Resident	N	Frequency of Visiting			
		Weekly+	Monthly	Less Often	Not Ascertainable
Spouse	2	2	-	-	-
Daughter(s)	9	9	-	-	-
Son(s)	4	4	-	-	-
Other adult children	13	9	1	1	2
Grandchild(ren)	18	7	6	4	1
Siblings	13	9	-	4	-
Other relatives	13	9	1	3	-
TOTAL	72	49	8	12	3

The 27 family members who were interviewed were asked about their visiting patterns and those of other available family members. The responses are presented in Table 42. All of the respondents reported that they personally visited on a weekly basis or more. In 13 of these cases (a little less than half) there were other adult children available. These other adult children for the most part visited on a weekly

basis. Grandchildren, siblings, and other relatives visited less frequently than adult children which was the pattern reported by the total sample of residents with family. These 27 family respondents are, therefore, a high involvement group since all of them visit weekly or more. This would suggest that the self-selected family respondents may be those who are the most involved compared to other families. The data on task performance would support this also.

Task Performance

In addition to visiting, the other operational indicator of shared function is task performance by families and friends within the nursing home. The data presented in Table 43 compare the level of task performance for residents with family and residents without families.

TABLE 43

FAMILY AND FRIEND TASK PERFORMANCE AS REPORTED BY RESIDENTS WITH FAMILY AND RESIDENTS WITHOUT FAMILY, BY TYPE OF TASK (Percentage Distribution)

Type of Task Performed	Residents With Families (N=64)	Residents Without Families (N=29)
Food treats	57	59
Shopping/errands	47	34
Gifts of money	37	28
Gifts of clothing	37	28
Sew, mend clothes	33	24
Conferences with staff	33	17
Books, plants	27	34
Grooming, personal care	25	14
Trips	25	28
Read, play games	18	21
Take to church	12	17
Cards on special occasions	78	45
Telephone calls	58	31

In the table, the tasks are listed in rank order based on the frequency with which they were cited as being performed. Tasks which families and friends are most likely to perform are provision of food treats, shopping and running errands, giving gifts of money, and giving gifts of clothing. All of these tasks were mentioned by 37 percent or more of the residents. The other tasks were performed to a lesser extent. Residents without families are comparatively disadvantaged in level of task performance for most task areas with the exception of food treats, gifts of books and plants, trips, being read to and playing games, and being taken to church. In other words, in those types of tasks which friends could easily do. Although it was not one of the more frequently performed tasks for either group, residents without family were most disadvantaged in having someone speak to staff about the quality of their care. A third of the residents with family reported that conferences with staff were held on their behalf as compared to only 17 percent of residents without family.

Two other indicators of shared function as operationalized by Dobrof were cards on special occasions and phone calls. Residents with family were much more likely to get cards on special occasions, 78 percent compared to 45 percent of residents without family. Given the fact that so many greeting cards are related to family relationships (i.e., Mother's Day, Father's Day, etc.), this is not too surprising. Residents with family were also more likely to receive phone calls (58 percent) than residents without family (31 percent).

The 27 family members who were interviewed were asked about the types of tasks which they performed for their relatives. Their responses were compared to that their aged relatives reported about their task

TABLE 44

FAMILY RESPONDENT TASK PERFORMANCE
ACCORDING TO RESIDENTS AND FAMILY

Type of Task Performed	Resident Response (N=27)	Family Response (N=27)
Food treats	22	22
Shopping/errands	21	22
Gifts of clothing	25	24
Gifts of money	13	12
Sew, mend clothes	12	12
Conferences with staff	10	16
Books, plants	14	15
Personal care, grooming	13	14
Trips	10	12
Read, play games	9	11
Take to church	1	1

performance. These responses are presented in Table 44.

The overall pattern of task performance was the same as that reported by most residents with family. The most frequently performed tasks were (in rank order) food treats, shopping and errands, and gifts of clothing. The degree of task performance was somewhat higher for these families according to their self-reports and the reports of their family members. For example, whereas 57 percent of all residents with family reported getting food treats, 22 of these 27 family members (81 percent) provided food treats. This is further evidence of the higher involvement of these families. There is close correspondence between the reports of these family members and their relatives. Only one task was reported with some discrepancy--conferences with staff. It is likely that aged residents do not always know when the family has

spoken to staff on their behalf. The family members were asked if they thought their presence in the nursing home was important and why. Their responses are presented in Table 45.

TABLE 45

ATTITUDES OF FAMILY MEMBERS ON THE IMPORTANCE OF FAMILY INVOLVEMENT, BY DEGREE OF IMPORTANCE AND REASON FOR IMPORTANCE

	(N=27)
Degree of Importance	
Very important	25
Somewhat important	2
Reason for Importance	
Gives a "personal touch"	7
Appropriate expression of concern for relative	7
Surveillance of staff	5
Makes relative more comfortable	3
No reason given	5
TOTAL	27

All of the family members felt it was important for them to take a part in their relative's care. Only two respondents did not feel it was very important. As to why it was important, the most frequently given reasons were that it gives a personal touch to the relative's care and that it was an appropriate expression of concern. Five family members mentioned surveillance of staff behavior and three felt it made the relative more comfortable in the nursing home. The degree of

visiting and task performance reported by these families indicates that they have acted on their convictions.

Finally, in attempting to ascertain if and how task performance differs for Black and white families of institutionalized aged, data on task performance for the study sample was compared with data on task performance for the Dobrof study sample. The results appear in Table 46.

TABLE 46

COMPARISON OF FAMILY TASK PERFORMANCE AS REPORTED BY RESIDENTS WITH FAMILY IN THE DOBROF STUDY AND THE STUDY SAMPLE, BY TYPE OF TASK (Percentage Distribution)

Type of Task Performed	Dobrof[a] Study Sample (N=215)	Study Sample (N=64)
Food treats	69	58
Gifts of clothing	49	37
Plants, books	47	37
Shopping	47	47
Trips	40	25*
Gifts of money	20	37**
Grooming/personal care	18	25
Cards on special occasions	52	78***
Telephone calls	49	58

[a]Dobrof, "Care of the Aged: A Shared Function," op. cit., Table XXXIV, p. 377.

*p < .05; **p < .01; ***p < .001.

A few findings are noteworthy. The first is that the overall pattern of task performance is not very different for the two samples. In both, the provision of food treats is the most frequently performed task, followed by gifts of clothing and shopping or errands. Secondly, although Black families had significantly higher rates of visiting, their level of task performance is not as high as it was for the families in the Dobrof study with the exception of four tasks: gifts of money ($p < .01$), cards on special occasions ($p < .001$), telephone calls (NS), and personal care and grooming (NS). These four were areas where task performance by Black families was proportionately higher. Black families were significantly less likely to take their relatives on trips. This could be explained by three possible factors: (1) the greater proximity of the families in this study sample to the nursing home, (2) the poorer health condition of most of the residents as compared to residents in the Dobrof sample, and (3) higher income of white families who would be more likely to own cars.

The importance of the telephone was mentioned by several of the residents and family members alike. Although some residents reported problems with phones because of abuse by other residents and staff, having to lock and unlock dials with arthritic hands, or not having the luxury of a private phone to receive calls, many indicated that it provided a way to keep in touch with busy or distant family members and friends who could not visit as often as they would like. This is perhaps best illustrated by an essay on one of the residents in the sample written by a friend who is a retired public health nurse. The administrator in one of the Black nursing homes provided a copy of the article which begins this way:

> One of my dearest friends is a lovely lady of 96 years of age, Aunt Mary. A widow for 40 years, without children of her own, she is the kind of grownup that not only loves children but whom children love.
>
> Aunt Mary developed diabetes in the latter years and has been an amputee for over ten years. She adjusted well to prosthesis and rehabilitation.
>
> Four months ago she was admitted to a nursing home located in the center of Harlem--a new voluntary 200 bed skilled nursing facility.
>
> When we helped to close Aunt Mary's apartment, my husband and I thought how much comfort it had been to her to have her telephone. So we decided to try to make it available now. My request for transfer of phone service was readily granted by the Nursing Home. This speaks volumes for their attitude.
>
> Aunt Mary has made the transition from independent living to the Nursing Home. She relates very well to staff. She has her favorite small possessions but her chief joy is her telephone which keeps her in touch with her loved ones and makes her "feel at home."[1]

Testing of Study Hypotheses

Using the Balance Theory of Coordination as a conceptual framework, several hypotheses were put forth in this study. These hypotheses help to partialize the Shared Function configuration into simpler relationships which can be examined in closer detail as a way of understanding (1) how families work with nursing homes, (2) what factors appear to affect the working together, and (3) how cooperative efforts affect resident satisfaction with care and resident morale. The remainder of this chapter will be devoted to the testing of these hypotheses using data obtained from Black aged residents, their family members and staff.

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[1] Excerpt from an essay written by a student in the Life Experience II class of the DC37 Retirees College. Author's name withheld upon request.

The first study hypothesis states that:

H_1: Congruence of ethnic orientation will be a greater determinant of social distance and shared function than the structural features of either the nursing home or the family.

In testing this hypothesis, it will be determined whether congruence in ethnic orientation as between the family and the nursing home and the resident and the nursing home is more related to felt social distance and shared function (i.e., visiting and task performance) than structural variables of either the family or the nursing home. In this context, "structural variables" of the nursing home refer to its degree of organizational complexity. Structural variables of the family refer to the responding family member's proximity to the nursing home, sex, social class, and the size of the rest of the family network. These are all factors which the Balance Theory of Coordination would define as "family resources." The family's ability to perform tasks and visit would be related to the availability of these resources. Sex of family member is included because more female relatives appear to be available to nursing home residents, both in numbers and in terms of their investment in care.

Congruence in ethnic orientation refers to two measures: (1) the degree of agreement between resident attitudes and the nursing home's practices with respect to ethnic factors in service delivery, and (2) the degree of agreement between family member attitudes and the nursing home's practices with respect to ethnic factors in service delivery. Operationally, those respondents who scored high on the Jenkins Ethnic Commitment Scale (i.e., above the Median) and were in an ethnic nursing home would be considered "congruent in ethnic orientation as would a respondent scoring low (i.e., below the Median) and

residing in a non-ethnic nursing home. If the respondent places greater importance on ethnic factors but is in a non-ethnic nursing home or vice-versa, "non-congruence in ethnic orientation" is said to exist.

Hypothesis 1 states that degree of social distance, degree of visiting and extent of task performance will be determined more by congruence in ethnic orientation than structural variables.

Expressed Social Distance

In trying to assess the degree of social distance which the family felt from the nursing home, several kinds of data were obtained. Family members were asked how they felt about the staff of the nursing home, how respectful and helpful the staff were, and how well they related to staff. In addition, some assessment was made of the family's involvement in activities such as attending special programs, fundraising, volunteering time, etc. Finally, family members were asked a series of questions designed to assess level of guilt experienced at having to place the aged relative.

Because of the small response from family members resulting in only 27 interviews and because those families who did respond appear to be such a select group, it was not surprising to find that there was very little variance on these social distance items. Families were uniformly positive in their feelings toward the staff and the facility regardless of variations in structural variables and they were low in feelings of guilt. The positive feelings about the staff and the

facility did not vary by organizational complexity of the nursing home or by the degree of congruence in ethnic orientation. With respect to participation in activities, however, these Black families were uniformly low in participation. This low participation in activities did not vary significantly by structural features of the family or by organizational complexity of the nursing home. Nor was the participation in activities related to congruence in ethnic orientation.

As operationalized in this study, there was not enough variance among the family respondents in expressed social distance to adequately test Hypothesis 1 as it pertains to social distance. One finding of note which did emerge from the analysis was the low participation of families in activities which are usually designed for families within the nursing home setting. Very few families volunteered time or attended special programs, or did fund raising. Given the high level of visiting from these families, their involvement in caring tasks for the aged resident, and their positive feelings toward the staff this finding is difficult to explain. The other finding was that these patterns did not vary by any of the independent variables specified in the hypothesis.

One possible explanation for the low participation in activities other than the shared function tasks is that given any limitations in visiting time, families prefer to spend it doing for the resident personally than for the facility at-large. In this context, it seems appropriate to recall that a significant number of residents mentioned knowing of problems which made family visiting difficult. Perhaps,

therefore, families have given priorities to the activities they wish to engage in given existing limitations.

Data were further analyzed to determine the relationship of structural variables and congruence in ethnic orientation of level of visiting and task performance.

Factors Affecting Level of Visiting

Data on the relationship between the family structural variables and level of visiting appear in Table 47. The sample size here was small, therefore, non-parametric statistics were used whenever statistical tests of significance were made on family respondent data. There were no significant differences in level of visiting as reported by family members which were related to structural features of the family.

With respect to organizational complexity and level of visiting, a significant difference was found to exist in level of family and friend visiting as reported by residents and the organizational complexity of the nursing home. The data in Table 48 indicate that there were significantly more family and friends in the "low-moderate" visiting category in the more complex nursing homes than the less complex nursing homes. It will be recalled that the "more complex" nursing homes were those which served over 200 patients. Low-Moderate visitors were those who visited less than weekly.

Level of visiting was examined in relation to congruence vs. non-congruence in ethnic orientation. The data in Table 49 indicate that level of visiting as reported by family members was not significantly related to whether or not the family and facility were congruent in

TABLE 47

LEVEL OF FAMILY VISITING AS REPORTED BY FAMILY MEMBERS, BY PROXIMITY OF FAMILY TO THE NURSING HOME, NETWORK SIZE, SEX OF KEY FAMILY MEMBER, AND SOCIAL CLASS POSITION OF FAMILY

	Level of Visiting	
	Low-Moderate	High
Proximity to Facility		
Near (N=14)	4	10
Far (N=10)	3	7
Network Size		
Small (N=20)	5	15
Large (N=7)	2	5
Sex of Key Family Member		
Female (N=21)	6	15
Male (N=9)	1	8
Social Class of Family Member		
Working or lower (N=15)	6	9
Above working (N=9)	1	8

TABLE 48

LEVEL OF FAMILY AND FRIEND VISITING, BY ORGANIZATIONAL COMPLEXITY OF THE NURSING HOME (Percentage Distribution)

	Level of Visiting	
	Low-Moderate	High
Organizational Complexity		
Less complex facility (N=53)	13	87
More complex facility (N=39)	31	69

Chi-square=5.37; df=1; $p < .05$.

TABLE 49

LEVEL OF FAMILY VISITING, BY FAMILY/FACILITY CONGRUENCE IN ETHNIC ORIENTATION

	Level of Visiting	
Family/Facility Congruence	Low-Moderate	High
Congruent families (N=13)	5	8
Non-congruent families (N=12)	1	11

ethnic orientation. Although there were no statistically significant differences by degree of congruence in ethnic orientation, non-congruent families reported a higher level of visiting. These numbers are too small to make too much of this finding. However, the Shared Function Thesis offers an explanation for this finding. To the extent that families feel the facility will not meet either the cultural or most idiosyncratic preferences of their aged relative, they may be more involved in the care to make up for what they perceive to be a deficit. This was supported to some extent by the statements of the administrator of Facility V, the less complex facility serving the smallest percentage of Black residents:

> On the whole, Black families visit more frequently than white families do. We did some research on visitations by families and friends. The average visits for non-Black families was nine visits per patient over a three month period or approximately two visits per month per patient. The Black families have 45 visits per month per patient for the three month period or approximately ten visits per month per patient. That is five times as many visits.

This finding is interesting and suggests an area for further study to the extent that a larger sample of Blacks and their families

associated with white nursing homes can be obtained.

In examining the relationships posited in H_1, levels of visiting were cross-tabulated with resident-facility congruence. The reasoning was that if residents perceive themselves to be "in alien territory" they may make more demands on family to visit. The results of this cross-tabulation appear in Table 50. No relationship was found to exist between these two variables. Finally, level of visiting was

TABLE 50

LEVEL OF FAMILY AND FRIEND VISITING, BY RESIDENT/FACILITY CONGRUENCE IN ETHNIC ORIENTATION
(Percentage Distribution)

	Level of Visiting	
Resident/Facility Congruence	Low-Moderate	High
Congruent residents (N=40)	23	77
Incongruent residents (N=48)	22	78

looked at by ethnic orientation of the nursing home as a final means of assessing the importance of ethnic orientation on level of visiting. These data are presented in Table 51. Although level of resident reported visiting was less for residents in the non-ethnic nursing homes (38 percent low-moderate) compared to 17 percent low-moderate in the ethnic nursing homes, this difference was not statistically significant as tested by the Chi-square test.

There was, then, only one independent variable which was significantly related to level of visiting: organizational complexity of

TABLE 51

LEVEL OF FAMILY AND FRIEND VISITING,
BY ETHNIC ORIENTATION OF THE NURSING HOME
(Percentage Distribution)

	Level of Visiting	
	Low-Moderate	High
Ethnic Orientation of the Nursing Home		
Ethnic nursing home residents (N=72)	17	83
Non-ethnic nursing home residents (N=21)	38	62

Chi-square=3.24; df=1; NS.

the nursing home. Visiting was significantly less in the more complex facilities. This is supported when level of visiting is examined for each facility individually. These findings are shown in Table 52.

TABLE 52

LEVEL OF FAMILY AND FRIEND VISITING BY FACILITY
(N=93)

Facility	N	Frequency of Visiting		
		Weekly+	Monthly	Less Often
Ethnic Nursing Home				
Facility I	19	16	2	1
Facility II	31	30	1	-
Facility III	22	17	3	2
Non-ethnic Nursing Home				
Facility IV	18	10	5	3
Facility V	3	3	-	-

The frequencies in Table 52 indicate that visiting weekly or more was reported by more residents proportionately in Facilities I, II and V--the less complex nursing homes. Lower visiting was reported for Facility III which is predominantly Black, but organizationally complex; and, the lowest proportion of weekly visiting was reported for Facility IV, the large, complex, predominantly white facility. Organizational factors, then appear to outweigh ethnic factors with respect to level of visiting. Hypothesis 1 is not supported as it pertains to level of visiting.

Factors Affecting Task Performance

The next step in the testing of Hypothesis 1 was to determine the relative effects of the independent variables on extent of task performance by families. In Table 53, task performance as reported by family members is examined for each type of task by the family structural or resource variables. There were some significant differences between families when divided along structural dimensions for a few of the tasks. Using the Fisher's Exact Test as a non-parametric test of significance, it was found that two tasks varied significantly by proximity of the family to the nursing home: sewing and mending clothes and taking the residents on trips. Both were performed more by families close by. Two tasks were found to vary by network size: trips and bringing books and newspapers. Families with larger networks were more likely to take the resident on a trip. This could be a function of two things: having more family members to get around to see and/or having more family members to share the task of taking a

TABLE 53

FREQUENCY OF FAMILY TASK PERFORMANCE, BY TYPE OF TASK AND BY FAMILY PROXIMITY, NETWORK SIZE, SEX OF KEY FAMILY MEMBER, AND SOCIAL CLASS POSITION OF KEY FAMILY MEMBER

Task Area	Proximity to Facility		Network Size		Sex of Key Family Member		Social Class[a] Position of Key Family Member	
	Near (N=14)	Far (N=10)	Small (N=19)	Large (N=7)	Female (N=21)	Male (N=7)	(-) or Working (N=15)	Above (N=9)
Gifts of clothing, jewelry	13	8	16	7	18	7	14	8
Food treats	13	6	16	5	18	5	12	8
Shopping	12	7	16	5	18	6	14	7
Sew, mend clothes	10	2*	9	3	13	1*	7	4
Take on trips	10	1**	6	5*	9	3	6	4
Conferences	9	6	13	4	14	3	8	6
Grooming, personal care	7	5	9	3	8	4	8	4
Newspapers, books	7	6	13	1**	11	4	9	5
Gifts of money	6	4	6	3	9	3	7	4
Read, play games	5	5	6	3	6	5	5	4
Take to church	7	1	2	-	1	1	-	2
Take to doctor/clinic	-	-	-	-	-	-	-	-
Mean Task Performance Score	8.0	6.5	7.9	6.3	8.1	6.4	8.0	7.8
Standard Deviation	2.7	3.6	3.5	2.1	3.4	2.5	2.8	3.2

[a] Based on Duncan Two-Factor Index of Education and Occupation.

*p < .05; **p < .01.

frail and aged relative around. Small networks were significantly more likely to bring books or newspapers, which, of course, is something that a lone family member could easily do. One task varied significantly by sex of the family member: sewing and mending clothes is the expected direction of greater performance by female relatives. None of the tasks varied significantly by social class position of the family member. When mean task performance scores[1] are examined for families divided along the structural dimensions, it appears that families near the facility, families of smaller size, and female family members are more involved in task performance. With respect to the effect of family structural variables on level of task performance, a mixed picture is gotten from these data. It seems safe to say that it depends on the specific task in question. A closer look at these relationships with a large sample of family members might reveal more than is able to be gleaned from the small family sample in this study.

The relationship of organizational complexity to level of task performance as reported by residents with families is examined in Table 54. Only one specific task was found to be performed significantly more often by families in less complex nursing homes: shopping and running errands. However, a perusal of the percentages for each task reveal that for every task used as an operational indicator of shared function, the performance was proportionately greater for families of residents in less complex nursing homes. Mean task performance scores were calculated for the two groups and compared in a t-test

---

[1]In calculating task performance scores, a 2 was given if the task was performed often, 1 for sometimes and a 0 for never. The sum of points for all tasks was the task performance score.

TABLE 54

RESIDENTS REPORTING FAMILY TASK PERFORMANCE, BY TYPE OF TASK AND ORGANIZATIONAL COMPLEXITY OF THE NURSING HOME (Percentage Distribution)

Type of Task	Residents in Less Complex Nursing Homes	Residents in More Complex Nursing Homes
	(N=38)	(N=27)
Shopping/errands[a]	63	25
Food treats	56	50
Gifts of clothing	50	36
Plants, things for room	45	25
Gifts of money	38	39
Conferences with staff	38	21
Sew, mend clothes	38	25
Newspapers, books		
Grooming/personal care	28	21
Trips	28	21
Read, play games	25	7
Take to church	18	4
Mean Task Performance[b] Score	9.31	5.70
Standard Deviation	5.9	5.3

[a]Chi-square=7.85; df=1; $p < .01$.

[b]T-test for Difference of Means, t=2.58, df=63, $p < .02$.

for difference of means. There was a statistically significant difference between the families in the two types of facilities. Thus for both level of visiting and task performance, degree of organizational complexity appears to be a significant factor. This finding was further supported by reports of the family members. As the data in Table 55 indicate families of residents in less complex nursing homes reported higher levels of task performance for every type of task. In

TABLE 55

NUMBER OF FAMILY RESPONDENTS REPORTING TASK PERFORMANCE, BY TYPE OF TASK AND ORGANIZATIONAL COMPLEXITY OF THE NURSING HOME

Type of Task	Less Complex Facilities	More Complex Facilities
	(N=16)	(N=11)
Gifts of clothing	16	10
Shopping	16	9
Food treats	14	10
Sew, mend clothes	11	3
Read, play games	10	2
Conferences with staff	10	8
Books, newspapers	10	6
Grooming, personal care	9	4
Take on trips	9	4
Gifts of money	8	5
Take to church	2	1
Take to doctor/clinic	-	-
Mean Task Performance[a] Score	8.8	5.9
Standard Deviation	3.3	2.3

[a]T-test for Difference of Means, t=2.58, df=25, $p < .02$.

addition, the mean task performance scores for the two groups were significantly different ($p < .02$).

Table 56 presents data on the relationship between congruence in ethnic orientation as between the family and the facility and task performance as reported by family members. Overall task performance did not vary significantly between congruent and non-congruent families, although family members whose ethnic orientation was congruent with the ethnic orientation of the facility were somewhat higher in task performance for most tasks examined.

TABLE 56

NUMBER OF FAMILY RESPONDENTS REPORTING TASK PERFORMANCE, BY TYPE OF TASK AND FAMILY/FACILITY CONGRUENCE IN ETHNIC ORIENTATION

Type of Task	Congruent Families	Non-congruent Families
	(N=13)	(N=13)
Shopping/errands	12	8
Gifts of clothing	11	12
Food treats	11	7
Conferences with staff	9	6
Grooming/personal care	7	4
Trips	7	4
Sew, mend clothes	6	5
Gifts of money	6	5
Books, newspapers	6	6
Read, play games	4	5
Take to church	2	-
Mean Task Performance Score	7.9	3.6
Standard Deviation	3.6	2.8

[a]Mann-Whitney U=58, NS.

Resident-facility congruence was also not significantly related to family task performance as indicated by the data shown in Table 57.

From this data, it can be seen that organizational complexity of the nursing home was significantly related to both level of visiting and extent of task performance by families. Neither the structural features of the family nor the degree of congruence in ethnic orientation was related to shared function.

These findings result in the rejection of Hypothesis 1. Thus,

TABLE 57

RESIDENT RESPONDENTS REPORTING FAMILY TASK PERFORMANCE, BY TYPE OF TASK AND RESIDENT/FACILITY CONGRUENCE IN ETHNIC ORIENTATION (Percentage Distribution)

Type of Task	Congruent Residents	Non-congruent Residents
	(N=27)	(N=35)
Food treats	56	57
Gifts of clothing	48	46
Shopping/errands	44	51
Gifts of money	33	40
Books, newspapers	33	29
Sew, mend clothes	30	34
Grooming/personal care	30	19
Conferences with staff	26	34
Trips	15	20
Read, play games	15	23
Take to church	7	11
Mean Task Performance Score	7.1	9.0
Standard Deviation	6.1	5.3

[a]T-test for Difference of Means, t=1.24, df=60, NS.

congruence of ethnic orientation does not appear to be a greater determinant of shared function than the organizational features of the nursing home by the family.

Employment of Mechanisms of Coordination

H_2: Where there is congruence in ethnic orientation, more mechanisms of coordination will be used by both the facility and the family in working with the other.

The Balance Theory of Coordination rests on the premise that formal organizations and primary groups must use some type of mechanisms

to coordinate their efforts and to maintain the optimal amount of distance (i.e., neither too close nor too distant so as to interfere with the ability to perform designated tasks). Hypothesis 2 states that more of these mechanisms of coordination will be used where there is congruence in ethnic orientation between the family and the nursing home. This hypothesis rests on the assumption that where there is congruence in ethnic orientation, there is a greater likelihood of too little distance between the family and the facility, thus more mechanisms of coordination would have to be employed to regulate the relationship.

The mechanism of coordination employed by the nursing homes are examined in Table 58. Data were not collected on how the facility employs these mechanisms with each individual family, thus the overall pattern described by the administrator will be assumed to be characteristic of how the nursing home works with all of its families.

These data do not adequately address Hypothesis 2 because responses were not obtained on how facilities work with individual families. However, family reports of how they work with the nursing homes do allow a greater degree of individuation, as well as the opportunity to see how congruence in ethnic orientation affects outreach efforts. The information in Table 58, however, does reveal a few interesting patterns which are worth mentioning. Of the 15 mechanisms of coordination as operationalized by Dobrof in her study on Shared Function, there are five which are used often by all of the nursing homes regardless of their ethnic orientation or size. These are:

1. Taking responsibility for securing information of family member's address and phone numbers.

TABLE 58

MECHANISMS OF COORDINATION USED BY FACILITIES IN WORKING WITH FAMILIES, BY TYPE OF MECHANISM AND EXTENT OF USE

Type of Mechanism	Extent of Use by Facility				
	I	II	III	IV	V
Facility takes responsibility for securing data on family member's address and phone.	Often	Often	Often	Often	Often
Facility takes responsibility for giving staff information about changes in family situation.	Often	Often	Often	Often	Often
Facility allocates staff to work with families and/or assigns staff during peak visiting hours.	Often	Sometimes	Often	Often	Sometimes
Assignment of specific staff to work with each family.	Sometimes	Often	Often	Often	On Occasion
Informs family of name, phone, office hours of staff.	Often	Often	Often	Often	Often
Facility has well-publicized and convenient visiting hours.	Yes	Yes	Yes	Yes	Yes
Facility supports visiting by provision of transportation, information, lounges, etc.	Often	On Occasion	Often	Often	Sometimes
Facility corresponds with families about institutional events.	Often	On Occasion	On Occasion	On Occasion	Often
Facility has systematic procedures for notifying family of changes in relative's condition and involvement of family in planning.	Yes	Yes	Yes	Yes	Yes
Facility plans programs for family members to help them understand the aging process, care of relatives, etc.	Often	Never	On Occasion	Often	Often
Facility includes family members in celebration of holidays and special events.	Often	Often	Often	Sometimes	Often
Facility invites family members to join Auxilliary groups, committees, or volunteer groups.	Often	Often	Often	Sometimes	Often
Fund-raising among the families of residents. residents.	Often	Often	On Occasion	On Occasion	On Occasion
Facility has stated expectations of family involvement.	Yes	No	Yes	Yes	Yes
Facility reinforces the involvement of families in the care of residents; encourages family input.	Often	Sometimes	Often	Often	Sometimes
Utilization Index	44	33	41	37	37

2. Giving staff information on changes in the resident's family situation.

3. Informing family of the names, office phones and office hours of staff members.

4. Having well publicized and convenient visiting hours.

5. Having systematic procedures for notifying the family of changes in the resident's condition.

These can all be categorized as the minimum and basic required linkages to family which are likely to be part of any formal organization. They relate to basic information gathering, record keeping and keeping both family and staff informed of where they can contact each other should such contact be required.

Most of the other mechanisms, however, require some additional effort and it is here where variations begin to take place. The use of mechanisms of this type appear to be more of a function of the needs of the nursing home than the needs of the families. For example, the smaller ethnic nursing homes were more likely to fund raise among families. They did not say that families were engaged to do the fund-raising which would be more of a way to pull families into the activities of the home. The ethnic nursing homes, with the exception of Facility I, were less likely to have programs for families educating them about the aging process. Both of the non-ethnic facilities reported doing this kind of education and counseling often. This may be related to limitations on staff, especially trained staff in the ethnic nursing homes. Or it may be due to the recency of their establishment which may require that limited resources be put to more immediate needs. The two complex facilities, III and IV were less likely to correspond with family members about institutional events. Given the number of residents which these facilities serve, there may

not be enough room to accommodate a large number of family members at one time. The lack of such outreach to families, however, may have consequences for the resident and the family's sense of well-being. It has already been shown that overall family visiting and task performance is less in these complex and large nursing homes. On the other hand, the larger facilities were more likely to assign specific staff to work with specific families. This would seem required and indicates a division of labor which makes handling the large numbers of residents and families more manageable. None of these patterns are conclusive. However, they do suggest that there is the chance that in seeking to meet their own organizational demands, nursing homes may overlook the needs of family members.

Hypothesis 2 is addressed more directly by the data in Tables 59 and 60. In these tables family reported use of mechanisms of coordination are examined by family-facility congruence in ethnic orientation and the ethnic orientation of the nursing home.

The data in Table 59 indicate that the mechanisms used most often by the families were (in rank order) conferences with staff about the relative's care, getting to know the staff by name, referral of potential applicants, and providing staff with phone numbers, address, etc. of family members. Again, the low level of participation in volunteer activities, attending programs, and membership in auxilliary organizations is observed.

Families which were congruent in ethnic orientation reported a greater proportion of complaints to staff and administration about treatment of their relatives. The difference, however, was not a significant one as measured by the Fisher's Exact Test. Families in both

TABLE 59

FAMILY RESPONDENTS REPORTING USE OF MECHANISMS OF COORDINATION, BY TYPE OF MECHANISM AND FAMILY/FACILITY CONGRUENCE IN ETHNIC ORIENTATION

Mechanisms of Coordination	Congruent Families	Non-congruent Families
	(N=13)	(N=11)
Conferences with staff	10	8
Getting to know staff by name	9	9
Referral of potential applicants	6	7
Provide staff with phone, address of family members	5	7
Volunteer services	5	3
Attend programs for families	5	7
Membership in auxilliary organizations	3	2
Complaints to staff, administration re treatment	6	2
Financial or in-kind services	5	3
Gifts/tips to staff	2	4
Letters of appreciation	2	-
Complaints to government agencies re treatment	-	-
Joining organizations like FRIA to bring about change in the facility	-	-

categories reported very low use of the more formal mechanisms of coordination like writing letters of appreciation to staff, complaints to government officials about treatment, and joining formal advocacy organizations like FRIA (Friend and Relatives of the Institutionalized Aged). There was no relationship statistically between the use of any of these mechanisms of coordination and the degree of family-facility congruence in ethnic orientation as tested by the Fisher's Exact Chi-square.

The data in Table 60 indicate that only one mechanisms of coordination was employed significantly more by families in non-ethnic nursing homes: financial or in-kind services. Families in the ethnic nursing homes were a little more likely to report giving staff names and addresses of family members and complaints to administrators about care. In all other areas, proportionately more families in non-ethnic nursing homes reported using these mechanisms of coordination but these differences were not significant.

Collectively, the data would reject Hypothesis 2. The use of mechanisms of coordination by families in reaching out to the facility do not appear related to congruence in ethnic orientation as between the family and the nursing home.

The Effects of Ethnic Orientation on Task Performance

H_3: There will be a relationship between the ethnic orientation of the facility and the nature of task performance by the family such that:

(a) In the Black nursing homes, tasks related to the preservation of cultural patterns will be performed by the facility on a uniform basis.

TABLE 60

FAMILY RESPONDENTS REPORTING USE OF MECHANISMS OF COORDINATION, BY TYPE OF MECHANISMS AND ETHNIC ORIENTATION OF THE NURSING HOME

Type of Mechanism	Total	Ethnic Nursing Homes	Non-ethnic Nursing Hones
	(N=25)	(N=18)	(N=7)
Family getting to know staff by name and position and seeking contact during visits.	19	12	7
Initiating conferences with staff re relative's care.	19	13	6
Took responsibility for giving Home names, addresses and phone numbers of family members or changes in each.	13	10	3
Referral of potential applicants to the Home.	13	8	5
Attends programs for families planned by the Home.	11	7	4
Complaints to Administration, Board or supervisors re unsatisfactory care of relative/self.	9	7	2
Family gives gifts or tips to staff.	7	5	2
Financial or in-kind services to the Home.	7	1	6*
Volunteers services to the Home.	7	3	4
Membership in Auxilliary organizations of the Home.	5	1	4
Letters of appreciation to the Home/staff.	2	-	2
Complaints to government, officials, media re unsatisfactory treatment.	1	1	-
Joining organizations to bring about changes of conditions in the Home.	-	-	-

*$p < .05$.

(b) In the white nursing homes orientation, tasks related to the preservation of cultural patterns will be performed by the family or close friends who act as functional kin.

Likwak and Dono characterized the ethnic group as an "in between group structure" because of its ability to meet the non-instrumental needs of large numbers of people. Using this as a framework, it was hypothesized that the Black nursing home would perform many of the tasks related to the maintenance of cultural patterns (i.e., ethnic foods, church services, etc.) to the Black residents on a uniform basis. This would not be the case in the white nursing homes; consequently, these tasks would fall to the family.

It has already been shown that the Black nursing homes (Facilities I, II and III) are providing ethnic foods on a regular basis, providing culturally accustomed church services, and other cultural components in activities. The same level of culturally relevant service delivery was not characteristic of the white nursing homes. Thus, there is already empirical support for Hypothesis 3a. The testing of Hypothesis 3b is now addressed. Of the twelve tasks which were used as operational indicators of shared function in this study, four are viewed as relating to the maintenance of cultural patterns: the provision of food treats which are frequently home made ethnic dishes or delicacies, trips, playing games, and taking the relative to church. To some extent, conferences with staff could fall into this category if the conference is related to the need for recognition of cultural preferences. Since this assumption cannot be made, it is not included in this analysis. Hypothesis 3b would suggest that families of residents in non-ethnic nursing homes would be more likely to perform tasks related to cultural maintenance as specified above than

TABLE 61

RESIDENT RESPONDENTS REPORTING FAMILY TASK PERFORMANCE, BY TYPE OF TASK AND ETHNIC ORIENTATION OF THE NURSING HOME (Percentage Distribution)

Type of Task	Ethnic Nursing Homes (N=51)	Non-ethnic Nursing Homes (N=16)
Shopping	55	25
Gifts of clothing[a]	51	25
Sew, mend clothes[a]	41	6
Gifts of money	39	38
Personal care/grooming	31	6
Take to doctor/clinic	10	--
Food treats	59	44
Trips to relatives, etc.	25	25
Read, play games	24	--
Take to church	16	--
Books, plants for room[b]	43	19
Conferences with staff	35	19
Mean Task Performance Score[c]	8.9	4.6
Standard Deviation	5.9	4.8

[a] Chi-square=5.24; df=1; $p < .05$.

[b] Chi-square=6.82; df=1; $p < .01$.

[c] T-test for Difference of Means, t=2.875, df=65, $p < .01$.

families of residents in ethnic nursing homes.

Task performance by families in ethnic and non-ethnic nursing homes as reported by residents by type of task appear in Table 61. Only two tasks were found to be significantly different for the two groups, neither of them were cultural maintenance tasks and neither was performed more by families in non-ethnic nursing homes. Only one of the cultural maintenance tasks was performed equally by families in

ethnic and non-ethnic nursing homes: taking trips. For each of the other three cultural maintenance tasks level of performance by families was greater in the ethnic nursing homes. These data would tend to reject Hypothesis 3b. In addition, when the mean task performance scores were compared for residents in ethnic nursing homes and those in non-ethnic nursing homes, the level of task performance for the former group was significantly greater ($p < .01$).

Family reported task performance shows a similar pattern as indicated by the data in Table 62. There were significant differences between the families in ethnic nursing homes and non-ethnic nursing homes on three tasks, only one of which was a cultural maintenance item: taking the resident to church and the difference was in the opposite direction from that predicted by Hypothesis 3b.

Finally, task performance is examined for each nursing home, by type of task in Table 63. The data clearly show that for each type of task with the exception of gifts of money, and in overall task performance as measured by the mean task performance score, the families in the ethnic nursing homes are engaged in a greater degree of shared functioning. To test this further, a t-test was performed comparing the mean task performance scores for Facilities III and IV. Both are bureaucratically complex, therefore, degree of organizational complexity is controlled for. The obtained t value was 2.12, $df=25$, $p < .05$.

These data lead to the rejection of Hypothesis 3b. One other interpretation can be made. The analysis of data in relation to the testing of Hypothesis 1 indicated that congruence in ethnic orientation was not significantly related to task performance. These data indicate, however, that the ethnic orientation of the facility appears

TABLE 62

FAMILY RESPONDENT TASK PERFORMANCE,
BY TYPE OF TASK AND ETHNIC ORIENTATION
OF THE NURSING HOME

Type of Task	Ethnic Nursing Homes	Non-ethnic Nursing Homes
	(N=22)	(N=8)
Gifts of clothing	20	7
Shopping	20	5
Sew, mend clothes[a]	13	1
Gifts of money	10	3
Personal care	10	3
Take to doctor/clinic	--	-
Food treats	18	6
Take to church[b]	15	1
Take on trips	11	2
Read, play games	9	3
Books, plants for room[c]	15	1
Conferences with staff	12	6
Mean Task Performance Score	8.5	5.3
Standard Deviation	3.2	1.8

[a] $p = .029$.

[b] $p = .009$.

[c] $p = .009$.

TABLE 63

FAMILY RESPONDENT TASK PERFORMANCE,
BY FACILITY AND TYPE OF TASK

Type of Task	Ethnic Facilities			Non-ethnic Facilities	
	I (N=18)	II (N=13)	III (N=14)	IV (N=13)	V (N=3)
Shopping/errands	14	9	5	2	-
Food treats	9	12	9	5	2
Gifts of clothing	9	8	6	1	-
Plants, room decorations	9	8	6	1	-
Sew, mend clothes	9	7	6	1	-
Gifts of money	9	6	5	6	-
Conferences with staff	7	7	4	2	1
Personal care	6	5	5	1	-
Trips	6	3	4	2	2
Take to church	5	2	-	-	-
Take to doctor	2	1	1	-	-
Mean Task Performance Score	10.5	8.3	7.7	3.5	-
Standard Deviation	6.4	5.3	5.7	4.0	-

to be related to task performance. Therefore, the degree to which the attitudes of a resident or family do or do not concur with the practice of the nursing home, is apparently not as important as the nature of the practice *per se* as it pertains to ethnic factors in service delivery. Even families who are not strongly committed to the importance of ethnic factors in service delivery, may feel more comfortable to come into the ethnic nursing, to relate to staff, and perform small tasks for their aged relatives. It would appear that Black families are most likely to visit and perform tasks in the small, less complex ethnic nursing homes.

H_4: There will be a relationship between degree of social distance from the facility as expressed by the family and degree of family visiting.

H_5: There will be a relationship between degree of social distance from the facility as expressed by the family and degree of family task performance.

Hypotheses 4 and 5 relate to degree of social distance and level of visiting and degree of social distance and extent of task performance, respectively.

The plan for testing these hypotheses called for comparing families "high" and "low" on the social distance items in terms of level of visiting and task performance. As indicated in the first part of this chapter all of the family members who agreed to be interviewed felt very close to the nursing home and its staff. Thus, there was not enough variance on the independent variable, social distance, to adequately test these hypotheses. The high level of visiting reported by these 27 family members, as well as the high degree of task performance reported are to some extent evidence in support of Hypotheses 4 and 5. Without a comparative group of families who feel more social distance, however, these hypotheses cannot be adequately tested.

The Relationship of Task Performance to Satisfaction with Care

H_6: There will be a relationship between the degree of shared function (task performance) and degree of satisfaction with care as expressed by both residents and family members.

One of the reasearch questions yet to be answered is how do ethnic, cultural and familial factors affect resident satisfaction with care? An effort will now be made to answer this question.

Residents were asked to express their level of satisfaction with

ten aspects of care. The cumulative ratings on these ten dimensions served as a numerical index referred to as the "Satisfaction with Care Score."

Resident evaluations of each aspect of care appear in Table 64. The dimensions of care are listed in the table in rank order

TABLE 64

RESIDENT SATISFACTION WITH CARE, BY ASPECT OF CARE AND LEVEL OF SATISFACTION
(Percentage Distribution)
(N = 93)

Aspect of Care	Level of Satisfaction		
	Very Satisfied	Somewhat Satisfied	Dis-satisfied
Medical/nursing care	67	28	5
Physical plant	61	31	8
Staff attitude	58	31	11
Other residents	56	40	4
Accessibility of staff	54	38	8
Emotional support	48	37	15
Social activities	43	35	22
Financial arrangements	41	46	13
Family involvement[a]	39	48	13
Food	39	40	31

Mean Satisfaction Score = 22.1
Standard Deviation = 4.8 (Possible range: 0-30)

[a]Percentages based on the 64 residents who have family.

according to the level of satisfaction expressed (high to low). As the data show, medical care and nursing care received the most satisfactory

evaluation from residents, followed by the physical plant of the nursing home, staff attitudes, the other residents, and accessibility of staff--all rated "very satisfied" by over 50 percent of the residents. There was among these, the greatest variance of opinion on staff attitudes, with 11 percent of the sample expressing dissatisfaction with this aspect of care. The aspect of care rated most negatively was the food and complaints were many:

> The food here is too starchy. I like more vegetables. The food has no taste, no seasoning.
>
> Many days the food is so bad that I will not eat it. I do not eat for the entire day sometimes.

Many residents are on low sodium or other special diets. If there is a preference for ethnic food, be it southern or Carribean cuisine, the lack of seasoning in the food will make it very unpalatable to most Black residents.

As noted, there was the most variation on "staff attitude" among those aspects of care rated more positively. Only 31 percent of the residents took a middle position on staff attitudes. Most were very positive, but there were also some residents who were very dissatisfied. The following responses illustrate both positions:

> Staff are available to listen at all times. All requests cannot always be met, there are too many people here for that. This is a very pleasant place to live. It couldn't be better for a place away from home.
>
> The staff here are great. They take me on trips and run errands for me--just like my own family.

Complaints about staff were usually made when the resident felt a lack of respect. In two cases which stand out because of the intensity of the protest, issues of cultural background--not race--were significant factors:

> There are some Haitian staff here and they do not treat me nicely. They are not respectful.
>
> Color makes no difference to me if they do not respect you and treat you properly. Some of the West Indian staff are not nice to me.
>
> At times the staff here do not give you good care. I dislike having to stay in bed until 12 noon because they are cleaning and dressing people. I want to get up at 6 a.m. as I have always done, but I have to have someone help me to dress.

Eighty-seven percent of the residents with family were satisfied with the degree of family involvement. In this context, it can be recalled that for most task areas, the families in this study sample were lower in task performance than the families in the Dobrof sample.

The level of satisfaction expressed by family members appears in Table 65. Aspects of care in this table are also listed in rank order (high to low) according to level of satisfaction expressed.

Family members gave the highest evaluation to the physical plant of the facility, followed by accessibility of staff, financial arrangements, staff attitude, and emotional support. Family involvement is evaluated more positively by these family members than by the overall resident sample, suggesting again the specialness of this family sample. Medical and nursing care was evaluated much lower by family members which might be explained by a greater degree of sophistication as health care consumers among the adult children as compared to aged parents. Like the residents, family members gave the food the worst evaluation. Out of a possible 30 points, the mean satisfaction score for family members was 24.2, standard deviation=4.6.

As a test of Hypothesis 6, mean satisfaction with care scores

TABLE 65

FAMILY RESPONDENT SATISFACTION WITH CARE, BY ASPECT OF CARE AND LEVEL OF SATISFACTION
(N = 27)

Aspect of Care	Level of Satisfaction		
	Very Satisfied	Somewhat Satisfied	Dis-satisfied
Physical plant	21	4	2
Accessibility of staff	21	4	2
Financial arrangements	19	8	-
Staff attitude	17	7	2
Emotional support	16	9	2
Family involvement	15	9	3
Social activities	14	10	3
Medical/nursing care	13	12	2
Other residents	13	12	2
Food	9	15	3

Mean Satisfaction Score=24.2
Standard Deviation = 4.6 (Possible range: 0-30)

were compared for residents with family and residents without family and by level of family task performance dichotomized (high = above the median task performance score of 8, and low = below the median).

The comparison of mean satisfaction scores by family status appear in Table 66. The results indicate that satisfaction with care was significantly higher for residents with family available.

Just having a family available is no guarantee of task performance, therefore, this alone is not an adequate test of Hypothesis 6. Next, mean satisfaction scores were compared for residents who reported high family task performance vs. low family task performance. These data are presented in Table 67.

TABLE 66

RESIDENT SATISFACTION WITH CARE (MEAN SCORE), BY AVAILABILITY OF FAMILY

Family Available	N	Satisfaction Score		
		Mean	Standard Deviation	T-test
Yes	62	23.2	4.5	t=3.32, df=89
No	29	19.8	4.6	p < .001

TABLE 67

RESIDENT SATISFACTION WITH CARE (MEAN SCORE), BY LEVEL OF FAMILY TASK PERFORMANCE

Level of Family Task Performance	N	Satisfaction Score		
		Mean	Standard Deviation	T-test
High (above Median)	27	23.4	4.6	t=2.88, df=62
Low (below Median)	37	21.6	5.1	p < .01

Residents with high family task performance were significantly more satisfied with their care ($p < .01$). Thus, Hypothesis 6 is accepted at the .01 level as it pertains to resident satisfaction with care.

Hypothesis 6 makes reference to both resident and family satisfaction with care. Therefore, mean satisfaction scores were compared for families who reported themselves as either high task performers or low task performers. These findings are presented in Table 68.

TABLE 68

FAMILY SATISFACTION WITH CARE (MEAN SCORE), BY LEVEL OF FAMILY TASK PERFORMANCE

Level of Family Task Performance	N	Satisfaction Score		
		Mean	Standard Deviation	U-test[a]
High (above Median)	14	24.9	5.1	U=39
Low (below Median)	11	21.8	4.3	$p < .05$

[a]The Mann-Whitney U was calculated from the raw scores for each group.

Because of the small N, raw satisfaction scores were used to compute the Mann-Whitney U statistic. The U-test proved significant at the .05 level indicating that there was a significant difference in the distribution of high and low satisfaction scores in the two groups of families. There were significantly more high satisfaction scores for families who were high task performers. Hypothesis 6 is therefore accepted at the .05 level as it pertains to family satisfaction with care.

Ethnic Orientation of the Nursing Home and Resident Satisfaction with Care

Although there was no formal hypothesis on the relationship of ethnic orientation of the nursing home and resident satisfaction with service, such a hypothesis is implicit in the nature of this study. Mean satisfaction scores were examined for each facility in the study. There were no statistically significant differences found between the

nursing homes on resident satisfaction with care, either by size of the facility or its ethnic orientation.

The small ethnic agencies, Facilities I and II had very similar mean satisfaction scores: 23.3 (standard deviation=5.5) and 22.1 (standard deviation=3.5), respectively. Facility III, the large facility serving 60 percent Black population, had the lowest satisfaction score: 19.1 (standard deviation=4.6). For the two non-ethnic nursing homes, the scores were similar to each other and to the small ethnic facilities. Facility IV, the large non-ethnic nursing home had a mean satisfaction score of 23.4 (standard deviation=3.2) and Facility IV, the small non-ethnic nursing home, had a mean score of 23.3 (standard deviation=5.7).

There is no observable difference between the facilities by ethnic orientation. The fact that Facility III had the lowest satisfaction score might lead one to speculate that there might be some aspects of the large, more complex ethnic nursing home which are problematic. This may be. However, no such assertion is made here for several reasons. The first is that these comparisons are made among single facilities rather than a sample of facilities which are representative of their types. Such comparisons, then, may reflect idiosyncratic differences of the individual facility. Secondly, of the nursing homes, Facility III is the most recently opened and the problems associated with program initiation may be present. Finally, the incorporation of ethnic factors in service delivery is only one aspect of care which may affect resident satisfaction. There are probably other factors which were not examined as part of this research.

Resident Morale

Resident morale in this research was operationalized in two ways: one was a subjective assessment of the level of morale, by staff, family, and the residents themselves. The other was an application of the Havighurst Life Satisfaction Scale to the resident sample.

The subjective evaluations of resident morale as reported by staff and residents appear in Table 69.

TABLE 69

COMPARISON OF STAFF AND RESIDENT EVALUATIONS OF RESIDENT MORALE
(Percentage Distribution)

Level of Morale	Source of Evaluation	
	Staff	Residents
	(N=93)	(N=93)
Very happy	16	32
Fairly happy	55	43
Not too happy	22	17
Not happy at all	7	8
TOTAL	100	100

The response of both indicate that the overall morale of these Black aged residents is fairly high. Seventy-one percent of the residents are at least "fairly happy" according to staff reports and resident self-evaluations indicate that 75 percent see themselves as at least "fairly happy." The residents were more likely to report themselves as "very happy" than were the staff, 32 percent as compared to 16 percent. The difference between staff evaluations and resident

self-evaluations of morale, then, are not related to distinctions between "good" and "poor" morale, but between the levels of morale within the "good" category. There are many possible explanations for this difference. Some possible ones are resident over-compensation for feelings of sadness and rejection, real differences in perception of affect as between staff and residents, or staff expectations that residents be less happy in the nursing home situation. The main finding in this regard is that overall resident morale is fairly high.

The family members interviewed were asked to evaluate the morale of their aged relatives. These assessments were then compared to staff evaluations and resident self-evaluations for these 27 cases. These comparative data appear in Table 70.

TABLE 70

COMPARISON OF RESIDENT, FAMILY AND STAFF EVALUATIONS OF RESIDENT MORALE

Level of Morale	Resident Response	Family Response	Staff Response
	(N=27)	(N=27)	(N=27)
Very happy	6	7	4
Fairly happy	14	15	16
Not too happy	6	5	6
Not happy at all	1	--	1

The overall correspondence is good between reports from these three sources. The staff were a little less likely to rate residents as "very happy" but the difference is very small. These evaluations

support the findings presented in Table 69. Most of these residents are "fairly happy."

The residents were asked to give a reason for the level of morale which they expressed. A few did not answer, but many gave specific reasons. About a third specified reasons for high self-evaluations. The most frequently cited was the good care provided by the nursing home and its staff (14 percent). For example, residents stated:

> I am getting what I have never had after a life of such hard work: good care and rest.
>
> Because the staff have gone overboard for me.
>
> Because I am not looking for miracles and I know my condition. No other Home could do better for me.

Other reasons for positive morale included the sentiment that one "has to make the best of it" (eight percent), the fact that good friends had been made among the other residents (five percent) and mentioned by one resident each were "it's better than being alone" and "because my family visits."

Residents who had mixed feelings and rated themselves as "fairly happy" usually stated that although life in the nursing home was not unpleasant, it was still not like being in one's own home. This reason was given by 30 percent of the residents in the study sample.

Eighteen percent of the residents gave reasons for low morale. Five percent said they wanted to leave the nursing home, but had no place to go and nine percent gave limited mobility as the reason:

> Because I have never been confined like this before.
>
> ~~I can't be happy like this. I was carefree and~~ independent until I went into the hospital, I can never be as happy as I was when I was independent.

Four percent of the residents mentioned poor staff attitudes and felt that they were not respected:

> I am not happy at all here. I do not have the necessary things which I like. I do not feel that the staff respect me. I have always been respected in my community and in my church. Now to have come to this.

Resident responses to the Havighurst Life Satisfaction Scale items are presented in Table 71.

The Scale can be divided into high morale items and low morale items. Residents were asked to indicate agreement or disagreement with the item. A score of 2 was given for agreement with a positive item or disagreement with a negative item, a score of 1 was given for each item to which the resident responded "I am not sure," and 0 was given for disagreement with a positive item and agreement with a negative item. There were ten items in the Scale. The possible score range was 0-30. The cumulative points for the ten items served as the "morale score" for the resident. The obtained median score was 17, the mean was 17.4 and the standard deviation was 7.2. Thus, if one uses 15 as the expected median score, the overall morale of these residents as measured by this Scale is somewhat higher than would be expected.

An item by item analysis of the responses shows some interesting patterns. Of the six positive items in the Scale, residents expressed the highest level of agreement with the statement, "As I look back on my life, I am fairly well satisfied." Eighty-three percent of the residents agreed with this statement. A large majority (77 percent) felt that they had gotten pretty much what they expected out of life. Given the social history of Blacks, these findings are somewhat surprising. Perhaps the comments of one 79-year-old woman help to explain:

TABLE 71

RESIDENT RESPONSE TO THE HAVIGHURST LIFE SATISFACTION SCALE ITEMS, BY LEVEL OF AGREEMENT WITH THE ITEM
(Percentage Distribution)
(N = 93)

Item	Level of Agreement Expressed		
	Agree	Disagree	Not Sure
High Morale Items:			
As I look back on my life, I am fairly well satisfied.	83	14	3
I've gotten pretty much what I expected out of life.	77	15	8
I have gotten more of the breaks in life than most people.	66	21	13
As I grow older, things seem better than I thought they would be.	56	32	12
I am just as happy now as when I was younger.	33	61	6
I have made plans for things I will be doing a month or a year from now.	22	75	3
Low Morale Items			
Compared to other people, I get down in the dumps too often.	27	69	4
Most of the things I do now are boring and all the same.	36	53	11
When I think back over my life, I didn't get most of the important things I wanted.	50	46	4
This is the dreariest time of my life.	50	44	6

Mean=17; Mean=17.4; Standard Deviation=7.2.

"People like me didn't want too much years ago." Only 33 percent of the residents felt that they were just as happy now as they were when they were younger and only 22 percent had made plans for things they would be doing a month or a year from now.

On the low morale items, residents were the least likely to feel that they got down in the dumps compared to most people. Only 27 percent agreed with this low morale item. One 85-year-old woman stated: "I never did get mad much. I wouldn't let things make me unhappy. If I saw something that was going to upset me, I would go away from it." About a third of the residents (36 percent) felt that most of the things they do now are boring and all the same." On the last two low morale items, residents were about equally divided. Fifty percent agreed with the statement, "As I look back on my life, I didn't get most of the important things that I wanted." This would seem to contradict the earlier finding that most were satisfied with their lives. It is possible that these elderly Blacks had to be satisfied with less--at least without the "most important things" they wanted. As one resident stated, "A lot of things that you really wanted, you weren't able to get." In this regard, the things which were most longed for were better educational and occupational opportunities, and the desire for more leisure time. The following comments serve to illustrate:

> I always wanted more education. My husband worked hard to give me the things I wanted, but I didn't have too much fun. I had to take care of my family--two boys. I always wanted to be a secretary.

> I would like to have had more education and more children. I have not accomplished as much as I would like.

> I had to work too much. I didn't have enough time to travel or do things that were fun. I really wanted to travel.

Fifty percent also felt that this was the dreariest time of their lives. For a community-based population, this question is asked in relation to old age as the "time of life." With an institutionalized population, however, the response could be in relation to either old age in general or to the specific circumstance of being in an institution or both. Unfortunately, as the question was asked, this differentiation cannot be made. In one sense, it really does not matter. For whatever reason, 50 percent of these aged residents felt that this was the dreariest time of their lives.

With respect to these morale items, the pattern seems to be one of decreasing morale or happiness as one moves from past to present and from global to specific references to life events. In spite of this, however, the overall level of morale is fairly good for this group of institutionalized Black aged.

Relationship of Shared Function to Resident Morale

Hypothesis 7 states that:

> There will be a relationship between degree of shared function and level of resident morale.

Four data analyses tasks were undertaken to test this hypothesis. The first was to see if staff evaluations of resident morale varied significantly by level of visiting as reported by residents. Secondly, to see if resident self-evaluations of morale varied significantly by level of visiting. The third was to determine if mean Havighurst Scale

scores were significantly different for residents reporting low to moderate visiting as compared to those reporting high visiting. Finally, the mean Havighurst scores were compared for residents who reported high family task performance as compared to those who reported low family task performance to see if they differed significantly.

In the following tables, "low to moderate" visiting refers those residents who reported visits on a less than weekly basis. "High" visiting refers to the residents visited on a weekly basis or more frequently. With respect to morale, "low" morale refers to those residents evaluated as "not too happy" or "not happy at all." "Good" morale refers to those residents evaluated as "very happy" or "fairly happy."

Staff evaluations of resident morale by level of family and friend visiting appear in Table 72.

TABLE 72

STAFF EVALUATION OF RESIDENT MORALE, BY LEVEL OF FAMILY AND FRIEND VISITING
(Percentage Distribution)

Level of Family/ Friend Visiting		Staff Evaluation of Morale		
		Total	Poor	Good
Low-Moderate	(N=20)	100	40	60
High	(N=73)	100	20	80

Chi-square=2.23; df=1; NS.

Staff members were twice as likely to rate morale "poor" for residents in the low-moderate visiting group, 40 percent as compared to 20 percent of the group which was visited weekly or more. The difference, however, was not a statistically significant one.

Resident self-evaluations of morale by level of family and friend visiting appear in Table 73.

TABLE 73

RESIDENT EVALUATION OF OWN MORALE, BY LEVEL OF FAMILY AND FRIEND VISITING
(Percentage Distribution)

Level of Family/ Friend Visiting	Resident Self-Evaluation of Morale		
	Total	Poor	Good
Low-Moderate (N=20)	100	33	67
High (N=73)	100	25	75

Chi-square=2.09; df=1; NS.

Although residents in the low-moderate visiting group were a little more likely to rate themselves as "poor" in morale, the difference was not great and not statistically significant. Using staff evaluations and resident self-evaluations of morale, Hypothesis 7 must be rejected. There is no significant relationship between level of visiting and resident morale. Because of the subjective nature of these assessments, this hypothesis was also tested using the Havighurst Scale score as the operational indicator of resident morale. A comparison of mean

TABLE 74

MEAN HAVIGHURST LIFE SATISFACTION SCALE SCORE,
BY LEVEL OF FAMILY AND FRIEND VISITING
(N = 93)

Level of Visiting	Havighurst Scale Score		
	Mean	Standard Deviation	T-test
Low to moderate (N=20)	16.7	7.1	t=.7089, df=91
High (N=73)	17.6	7.3	NS

Havighurst Scale scores for residents in the low-moderate vs. high visiting group appear in Table 74.

The data indicate that the mean Havighurst Scale score was lower for residents in the low-moderate visiting group, 16.7 compared to 17.6 for the high visiting group. A t-test for difference of means failed to reject the null hypothesis at the .05 level for a two-tailed test. There appears to be no association between level of visiting and morale as measured by the Havighurst Scale, therefore Hypothesis 7 is rejected.

Finally, morale scores were looked at in relation to level of family task performance. These findings are presented in Table 75. As the data show, the residents who reported lower task performance by family members did have lower morale scores on the average. The mean score for the low task performance group was 16.7, compared to 18.2 for the high task performance group. These differences were not statistically significant. A t-test for difference of means at the .05 level

TABLE 75

MEAN HAVIGHURST LIFE SATISFACTION SCALE SCORE, BY LEVEL OF FAMILY TASK PERFORMANCE (N = 64)

Level of Family Task Performance	Havighurst Scale Score		
	Mean	Standard Deviation	T-test
Low (below Median) (N=26)	16.7	7.3	t=.898, df=62
High (Median or +) (N=38)	18.2	5.9	NS

for a two-tailed test, failed to reject the null hypothesis.

Thus, for both components of shared function: visiting and family task performance, there was no statistically significant relationship to resident morale. Dobrof reported similar findings in her research. She wrote:

> The fact that a statistically strong association between a high frequency of visiting and familial task performance and high morale cannot be claimed, however, does not carry with it the conclusion that these items are of no importance. The family did raise the level of provision and the family was most able to meet the idiosyncratic needs of the resident.[1]

The other findings presented in this chapter, expecially those showing the strong relationship between shared function and resident satisfaction with care would support the Dobrof interpretation. A further explanation is that satisfaction with care is much more focused on the immediate institutional experience. Morale or happiness is much more global and is really the result of the cumulative

[1] Dobrof, op. cit., p. 551.

effects of a lifetime of experience. In this context, satisfaction with care and morale are distinct and different constructs. It is possible, therefore, that shared function may affect one without significantly affecting the other.

Resident Characteristics and Their Effect on Shared Function

Some of the studies cited in Chapter II indicate that personal characteristics of the aged relative often affect the nature of relationships with other members of the family. Studies of Black aged in the community have shown, for example, that factors such as sex of the parent, age of the parent, health status, social class, and rural vs. urban residence affect intergenerational relations in some Black families. One question is whether or not such factors might affect relationships between institutionalized Black aged and their families. The final hypothesis in this study states that:

H_8: Personal characteristics of the aged resident, specifically, age, sex, physical health status and mental health status will affect the degree of family visiting and family task performance.

Data on level of visiting as reported by residents by age, sex, physical health status and mental health status of the residents are presented in Table 76. The results indicate that younger residents were somewhat less likely to be in the high visiting group, as were males and those in poorer mental health. None of these differences, however, were statistically significant according to the Chi-square test at the .05 level. Thus, Hypothesis 8 is rejected as it pertains to level of visiting.

TABLE 76

LEVEL OF FAMILY VISITING, BY RESIDENT CHARACTERISTICS: AGE, SEX, PHYSICAL HEALTH STATUS AND MENTAL HEALTH STATUS (Percentage Distribution) (N = 64)

Resident Characteristic	Level of Visiting			
	Total	Low to Moderate	High	
Age				
79 or younger	100	28	72	NS
80 or older	100	15	85	
Sex				
Male	100	29	71	NS
Female	100	18	82	
Physical Health				
"Poor" (below Median)	100	20	80	NS
"Good" (above Median)	100	20	80	
Mental Health				
"Poor" (below Median)	100	25	75	NS
"Good" (above Median)	100	20	80	

The results of the comparison of mean task performance scores by resident characteristics appear in Table 77. Family task performance was found to vary significantly by two of the four resident characteristics: age and sex.

Data presented in Table 77 show that younger residents and males were significantly lower in reported family task performance. Physical health status and mental health status were not related to family task performance. Hypothesis 8 is supported for age and sex, but rejected for mental health and physical health status. The findings on age and sex are interesting and are in agreement with studies of Black aged in

TABLE 77

MEAN FAMILY TASK PERFORMANCE SCORES, BY RESIDENT CHARACTERISTICS: AGE, SEX, PHYSICAL HEALTH STATUS, AND MENTAL HEALTH STATUS (N = 64)

Resident Characteristics	Mean Task Performance Scores		
	Mean	Standard Deviation	T-test
Age			
79 or younger	6.0	5.2	t = -5.82, df=62
80 or older	9.6	6.1	p < .001
Sex			
Male	5.5	5.3	t = -2.62, df=62
Female	8.6	5.9	p < .02
Physical Health			
"Poor" (below Median)	8.2	5.4	NS
"Good" (above Median)	8.2	6.3	
Mental Health			
"Poor" (below Median)	8.2	5.2	NS
"Good" (above Median)	8.3	6.6	

the community. The lack of relationship between health and mental health status is revealing because it suggests that even when the condition of the aged relative is seriously deteriorated, family members are as equally involved and committed as are the family of residents who are in better health.

Relationship of Health Status to Resident Morale

The lack of significant relationship between shared function and resident morale suggests that there are overriding factors which

determine level of morale regardless of family behaviors. Some possible ones were alluded to previously. One factor, however, which has been found to relate to morale in studies of aged in the community and in institutions is health status.

One question is whether or not this relationship pertains for aged Blacks in institutions. Based on data available from this study, the answer is yes. Several analytical steps were undertaken in answering this question. First the personal characteristics of the resident (i.e., age, sex, physical health status and mental health status) were cross-tabulated with (1) staff assessments of resident morale, and (2) resident self-assessments of morale. The results of this analysis appear in Table 78. They show that neither age or sex is significantly related to level of morale. However, staff reports indicate that residents with poorer physical health and mental health have lower morale. Although the resident self-assessments were in this direction, there was not a statistically significant relationship between health status and resident morale. Staff, however, were significantly more likely to rate sicker residents as having lower morale. According to staff reports, 39 percent of the residents in poor physical health had low morale, compared to only 18 percent of residents in good physical health ($p < .02$). The difference was even greater for residents in poor mental condition where staff reported that 44 percent had low morale, compared to only 12 percent of residents in better mental condition ($p < .001$). As was noted previously in this chapter, staff appear to rate these residents lower in morale than do the residents themselves. Although resident reports were not as strong in showing a relationship between health status and morale,

TABLE 78

COMPARISON OF STAFF AND RESIDENT EVALUATIONS OF RESIDENT MORALE, BY RESIDENT CHARACTERISTICS: AGE, SEX, PHYSICAL HEALTH STATUS AND MENTAL HEALTH STATUS
(Percentage Distribution)
(N = 93)

Resident Characteristic	Staff Evaluation of Resident Morale		Self-Evaluation of Resident Morale	
	Low	High	Low	High
Age				
79 or younger	21	79	24	76
80 or older	26	74	33	67
Sex				
Male	19	81	25	75
Female	27	73	26	74
Physical Health				
"Poor" (below Median)	39	61[a]	28	72
"Good" (above Median)	18	82	21	79
Mental Health				
"Poor" (below Median)	44	56[b]	34	66
"Good" (above Median)	12	88	20	80

[a] Chi-square=6.138; df=1; $p < .02$.

[b] Chi-square=14.09; df=1; $p < .001$.

they were in this direction.

Havighurst Scale scores were also compared by resident age, sex, physical health status, and mental health status. The data presented in Table 79 indicate that mean morale scores were lower for younger residents, men, and residents in poorer health, both mental and physical. Only one variable, however, produced statistically significant differences in Havighurst Scale scores: physical health status.

All of these analyses have relied on the staff assessments of

TABLE 79

MEAN HAVIGHURST LIFE SATISFACTION SCALE SCORES, BY RESIDENT CHARACTERISTICS: AGE, SEX, PHYSICAL HEALTH STATUS AND MENTAL HEALTH STATUS (N = 93)

Resident Characteristic	Mean Havighurst Scale Scores		
	Mean	Standard Deviation	T-test
Age			
79 or younger	17.6	6.6	NS
80 or older	16.7	7.3	
Sex			
Male	15.4	6.3	NS
Female	17.9	6.4	
Physical Health			
"Poor" (above Median)	15.4	6.9	t=2.15, df=87
"Good" (below Median)	18.5	6.6	p < .05
Mental Health			
"Poor" (above Median)	17.8	7.3	NS
"Good" (below Median)	16.1	6.6	

resident physical and mental health status. As one final procedure in looking at the relationship between health and morale, mean Havighurst Scale scores were looked at in relation to the residents' assessments of their own health status which they rated as "good," "fair" or "poor." These data are presented in Table 80.

The evidence in support of the relationship of health to morale is even stronger. The greatest difference in life satisfaction and morale as measured by the Havighurst Scale was found between residents in "good" health and those in "poor" health ($p < .001$). Assessments of family behaviors and their potential impact on morale of aged residents in nursing homes should be viewed in relation to these findings.

TABLE 80

MEAN HAVIGHURST LIFE SATISFACTION SCALE SCORES,
BY RESIDENT SELF-EVALUATED HEALTH STATUS

Self-Evaluated Health Status	Mean Havighurst Scale Scores	
	Mean	Standard Deviation
"Good" (N=35)	18.9	5.9
"Fair" (N=41)	16.7	7.4
"Poor" (N=17)	12.3	7.6

T-test ("Good" vs. "Poor"), $t=3.83$, $df=49$, $p < .001$.

T-test ("Good" vs. "Fair"), $t=2.58$, $df=74$, $p < .02$.

T-test ("Fair" vs. "Poor"), $t=3.02$, $df=55$, $p < .01$.

Summary

The data presented in this chapter on the Shared Function Thesis and its applicability to the Black institutionalized aged indicate that on both dimensions of shared function, visiting and task performance, family and friends of Black nursing home residents are taking part in caring functions. When compared to national norms and to a sample of predominantly white residents in a similar study, Black nursing home residents in this study were significantly higher in the degree to which they were visited by family and/or friends. The pattern of task performance was found to be similar to that reported for white families of institutionalized aged with provision of food treats, shopping and errands and gifts of clothing predominating. Black families were more likely to give gifts of money and to provide personal care as compared to the predominantly white sample in the Dobrof study.

CHAPTER VIII

SUMMARY AND CONCLUSIONS

This study had three main goals. The first was to describe the institutionalized Black aged in terms of their relevant demographic characteristics and reasons for admission. The second was to explore the relative importance of ethnic and cultural factors in service delivery to this population. The third was to examine the role which the Black family plays within the institutional setting as measured by patterns of visiting and task performance. In this regard, one of the central research questions was how family involvement affects resident satisfaction with care and resident morale. Several study hypotheses were made about the family's role and how the family works with the nursing home toward the shared goal of optimum care of the aged resident. These hypotheses grew out of an application of the Shared Function Thesis to the situation of aged Blacks in institutional long-term care.

Several important findings emerged in each of these three areas. Data on the demographic characteristics of this population were compared to existing norms for Black aged in the community. The two groups were found to be similar with respect to religion, previous occupation and level of education. However, the groups differed significantly on two key variables which have been shown in previous

research to be related to risk of institutionalization: age and marital status. The institutionalized persons in the study sample were significantly older and there were many more widowed and never married persons among the institutionalized aged, as compared to those still residing in the community. These findings seem to indicate that lack of spouse or other familial supports in the face of advancing age and impairment is a major reason for admission to the nursing home. It was also found that availability of family was significantly related to sex of the older person. Black aged males in the study sample were less likely than aged females to have family available. When family was available, the men were more likely to report that they were not close to family. To the extent that availability of family and good family relationships are related to the quality of care, Black aged males may be disadvantaged relative to aged females in the nursing home.

With respect to health status, the aged Blacks in the study sample were found to be most impaired in their ability to undertake the tasks of daily living such as dressing, grooming and bathing without assistance. Most had limited mobility. When staff, resident and family member responses to questions on reason for admission were analyzed, these factors were found to be related to reason for placement. The three most commonly cited reasons were (in rank order) inability to manage alone, poor physical health, and lack of family supports or the inability of the family to continue care.

Findings on the decision-making process surrounding the admission indicate three main points. First, hospital and medical staff play a central role in helping the aged person or his family make the decision to seek admission. They were also the major source of referral to

specific nursing homes. Secondly, in most cases, alternatives to the nursing home were not explored prior to admission. And third, acceptance of the decision to enter the nursing home was high for both aged residents and family members. The high level of acceptance appeared to be related to a recognition of the degree of impairment and the need for skilled nursing care.

On the question of ethnic factors in service delivery, two major findings emerged. The nursing homes in the study could be labeled as either ethnic or non-ethnic in their orientation as it pertains to Black culture. The ethnic nursing homes serve a majority of Black residents and were more likely than the non-ethnic nursing homes to include cultural components in routine activities. These components included the celebration of holidays important to Black aged, the regular provision of ethnic foods, provision of church services in a manner familiar to aged Blacks, and the inclusion of Black music, folklore and art in social activities. The second finding was that consumer attitudes were related to the ethnic orientation of the host facility. This was more true for issues of matching provider and consumer on the basis of ethnicity than for the inclusion of cultural components in routine activities, for which there was ample support by residents and family member respondents regardless of the ethnic orientation of the host facility.

Administrative staff, aged residents and family member respondents in ethnic nursing homes were more likely than respondents in non-ethnic nursing homes to feel that Black representation on the staff was important and that the administrator of the nursing home should be Black. They were also more likely to support the establishment of

nursing homes owned and operated by Blacks for their own aged. Thus, the relationship between the ethnic orientation of the nursing home and attitudes of its clientele are clear. What is not clear is the direction of causality. Do attitudes flow from the nature of service delivery or do attitudes dictate selection of a nursing home whose service delivery patterns are in agreement with consumer preference? This is one area which warrants further study, and needs to be made prior to selection of the specific home.

With reference to the third area assessed in this research, the role of the family within the nursing home, data were obtained on patterns of visiting and patterns of task performance by family members and friends.

On both indicators of shared function, visiting and task performance, there was evidence that family continue to play a meaningful role in the lives of their aged members even when institutionalization has occurred. Study findings indicate that friends also visit frequently and often perform tasks in addition to family members or in lieu of family when no blood relatives are available. Resident and family reported levels of visiting that were very high and above established norms for all Blacks in nursing homes, as reported in the 1973-74 National Nursing Home Survey. The reported level of visiting was also significantly higher than that reported for a sample of predominantly white, middle-class institutionalized aged in a similar study in the same locale (Dobrof study).

With respect to task performance by family and friends, the most commonly reported tasks performed were (in rank order) the provision of food treats, shopping and running errands, and the provision

of clothing. The Black residents in this study sample were significantly more likely than the white residents in the aforementioned study to report that family and friends gave gifts of money and performed tasks related to personal care and grooming of the aged person.

The application of the Shared Function Thesis to the situation of aged Blacks in nursing homes resulted in the formulation of eight hypotheses. When obtained data were applied to the testing of the hypotheses, three were supported or partially upheld, three were rejected and two could not be tested.

Hypotheses 3, 6 and 8 were partially upheld by the data. Hypothesis 3 states that:

H_3: There will be a relationship between the ethnic orientation of the facility and the nature of task performance by the family, such that:

(a) In the facilities with a stronger Black ethnic orientation, tasks related to the preservation of cultural patterns will be performed by the facility on a uniform basis.

(b) In the facilities with a stronger non-Black ethnic orientation tasks related to the preservation of cultural patterns will be performed by the family or close friends who act as functional kin.

There was support for Hypothesis 3a, but not for Hypothesis 3b. Specifically, nursing homes with a stronger Black cultural orientation did perform tasks related to the preservation of cultural patterns on a uniform basis. Hypothesis 3b stated that in nursing homes with a non-Black ethnic orientation, tasks related to cultural preservation would fall to the primary group. This was not supported. Black residents in non-ethnic nursing homes did not report significantly higher family performance of tasks related to preservation of cultural patterns such as food treats and taking the resident to church. As was

noted previously, overall task performance was lower in the non-ethnic nursing homes. This would suggest that factors other than resident need or preference with respect to cultural maintenance may affect family behaviors in this regard.

H_6: There will be a relationship between the degree of family task performance and satisfaction with care as expressed by both the resident and the family.

There was support for this hypothesis. Both resident and family satisfaction scores were significantly related to level of visiting and task performance in a positive direction.

H_8: Personal characteristics of the aged resident (specifically age, sex, physical health status and mental/emotional health status) will relate to the degree of family visiting and task performance.

With respect to the relationship of personal characteristics of the resident and shared function as stated in Hypothesis 8, both sex and age were found to be significantly related to shared function. Black male residents and younger residents were significantly less likely to report task performance by family and friends. Part of this can be explained by the fact that more of the younger residents are males and more males reported lack of family and estrangement from family. Given the support for Hypotheses 6 and 8, one might expect that the male Black nursing home resident would be less satisfied with his care. This was not the case and it might be hypothesized that given the lack of familial supports, these aged males were grateful to live in a protected environment where at least their basic physical needs were met. Physical health status and mental health status were not related to either the level of visiting or task performance. These

findings would suggest that family and friends continue to visit and continue to perform tasks for their aged members in spite of deterioration in physical and mental condition.

The three hypotheses which were not supported were Hypotheses 1, 2 and 7.

H_1: Congruence of ethnic orientation will be a greater determinant of social distance and shared function than the structural features of either the nursing home or the family.

When the data were analyzed, as a test of this hypothesis, two factors were found to be related to level of shared function: the organizational complexity of the nursing home and the ethnic orientation of the nursing home. Task performance and visiting were higher in the less complex and ethnic nursing homes. Several hypotheses might be offered to explain these findings. With respect to the role of organizational complexity, Black families may be less willing or able to engage in sharing relationships where to do so requires an understanding and knowledge of how to negotiate a large and complex bureaucracy. Perhaps staff in the more complex nursing homes must, by necessity, devote more of their time to management tasks related to the running of a large organization than to outreach and engagement of individual families. The sheer numbers of family and friends who would be involved in a situation in which three to four hundred residents are cared for may make the regular provision of special programs for families and friends prohibitive.

The lack of support for the importance of congruence in ethnic orientation should not be interpreted as conclusive evidence that this variable is unimportant. Congruence, which was the agreement or

consumer attitudes and nature of service provision as they relate to ethnically relevant programming, was operationalized by application of the Jenkins Ethnic Commitment Scale which is new and still to be widely tested in studies on different populations. Because of this, the role of measurement error as a possible explanation for rejection of this hypothesis cannot be ruled out. Although congruence in ethnic orientation was not significantly related to shared function, the ethnic orientation of the nursing home was. This finding would suggest that ethnic factors do, indeed, play a significant role in the degree to which Black families in the study sample visitied and performed tasks. It could be hypothesized that even when Black families or aged residents do not endorse a strong ethnic position on ideological grounds, they are, nevertheless, still more comfortable to relate to and work with staff who are of the same ethnic group as themselves. This is another area in which further research needs to be undertaken.

H_2: Where there is congruence in ethnic orientation, more mechanisms of coordination will be used by both the facility and the family in working with each other.

Hypothesis 2 was not supported by the data obtained in this study. There was no relationship found between congruence in ethnic orientation and the use of mechanisms of coordination by either the family or the nursing home.

H_7: There will be a relationship between degree of shared function and level of resident morale.

There was no relationship found between shared function and level of resident morale. High levels of visiting and task performance by family and friends were not significantly related to either resident

self-reports on level of morale or to morale as measured by the Havighurst Life Satisfaction Scale. The relationship between shared function and resident morale may have become clearer if possible intervening factors such as length of stay were taken into account. A limitation of this research is that such possible intervening variables were not identified. Morale was found, however, to be related to physical health status. Residents in poorer physical health as assessed by staff evaluations and self-report had significantly lower morale.

H_4: There will be a relationship between degree of social distance from the facility expressed by the family and degree of visiting.

H_5: There will be a relationship between social distance from the facility expressed by the family and the degree of familial task performance within the facility.

Hypotheses 4 and 5 could not be tested because of the insufficient response from family members and lack of variance within the responding group on the major study variable of social distance.

Recommendations

The major findings in this study lead to the formulation of several recommendations. The first relates to demographic data and statistical profiles of the institutionalized aged population. There has been for some years a continuing debate about separate statistical profiles of minority group individuals in relation to needs assessment and service utilization. Opponents have pointed to instances where ethnic and racial data have been used against minority persons. The potential for misuse is certainly a valid concern. On the other hand, the lack of relevant demographic data on minority groups, or subgroups within the ethnic group like the aged, makes assessment of need very difficult. As was noted in the description of the sampling strategy employed in this research, there were no available statistics

on the Black institutionalized population in New York City. It would seem that such a data base would be necessary to plan adequately for this population and to determine whether patterns of need for this group differ from all institutionalized aged. One recommendation, therefore, is that data on the aged population in nursing homes and other long-term care facilities be disaggregated by race or ethnicity. It would also be helpful if data on aged persons still residing in the community are disaggregated by race or ethnicity as a means of monitoring changes in identified risk factors for particular minority groups.

Much is known about factors which place an aged person at risk of institutionalization. This study has shown that most of the identified risk factors are applicable to the situation of aged Blacks. It should be possible, therefore, to identify among the Black aged, those persons who are at greater risk of becoming institutionalized (i.e., the frail, those without family or estranged from family, the very old, etc.). Wherever feasible, supportive services should be provided for the Black aged "at risk" in order to prevent premature or unnecessary institutionalization. Such services might include sheltered living environments with medical service on site, homemaker services, visiting nurse services, and meals-on-wheels. Most of these services have not been well developed in areas where large numbers of poor Black aged reside.

The earlier admission of Black aged males to nursing homes and the greater lack of family supports for these aged men, leads one to conclude that this group probably has special needs related to care in the later years. One recommendation is that this group be the focus

of more intensive research aimed at identifying special needs. Nursing homes may have to make a special effort to provide and/or foster primary group relationships for Black male residents in the absence of family. Some possible suggestions are the recruitment of male volunteers and the formation of men's clubs within the nursing home for those who are able to participate.

On the basis of findings related to ethnic factors in service delivery, three recommendations can be made. First, whenever possible, Black cultural components should be included in routine services wherever Blacks are part of the resident population. This would include celebration of holidays important to Black aged, provision of ethnic foods, church services, prayer meetings and bible reading sessions as relevant social activities. There will always be individual variations on dominant cultural themes. To avoid making assumptions about what an aged resident would enjoy, it might be a good idea to ask. Secondly, aged Blacks who are in predominantly white nursing homes should not be overlooked simply because they are so few in number. Every effort should be made to recognize their cultural preferences in food and social activities. The third recommendation relates to staff training. It is suggested that part of in-service staff training include attention to Black cultural patterns, particularly Southern customs and folkways since so many Black aged have Southern roots. Staff, particularly those in nursing homes where Blacks are a small minority, might be helped through training to recognize signs of isolation and withdrawal.

Finally, there are three recommendations related to study findings on shared function. First the important role which friends play

in the lives of the Black institutionalized aged would suggest a need for a broad definition of "family" in dealing with aged Blacks. In many ways, friends act as functional kin. When "family" activities are planned by the nursing home, these special friends might be included. This would be especially important for the resident whose major primary group relationships are grounded in the friendship, as opposed to kinship, network.

Secondly, the nursing homes' policies on visiting, visiting hours and activities for family and friends need to be examined for their effect on family behavior. Do they encourage or discourage family involvement in the nursing home in either manifest or latent ways. For example, are visiting hours flexible enough to allow working adult children to visit for sufficient periods of time? Would visiting policies prohibit a visit from a young grandchild? Would staff permit a family member to assist with the bathing and grooming of a resident if conditions permit?

Third, on the basis of study findings, it would appear that large, bureaucratically complex nursing homes may have to make special efforts to reach out to Black families. This would also appear to be true for non-ethnic nursing homes, as well. The strong relationship found in this research between family involvement and resident satisfaction with care leads one to conclude that involvement of family and friends is vital to optimum care of the institutionalized aged. Nursing homes need to make every effort possible to encourage this involvement.

ADMINISTRATOR INTERVIEW

Name :_____ Position:_____

Facility:_____ CODE: _____

Interviewer:_____Date of Interview:_____

I. History and Auspice

a. When facility was founded:_____

b. Was founding group of a specific ethnic, religious, or social group? _____Yes_____No. Who were founders?

c. Has auspice or sponsorship changed over the years? __Yes__No
If so, how and why? (Use back of page to record answer)

e.___Public ___ Voluntary ____Proprietary _____Other

II. Size and Staffing Pattern

a. Total # of residents:_____ b. # of Blacks:_____%_____

c. Average length of resident stay:_____d. %Male_____%Female:____

e. Average resident age:_____

f. # of total staff:_____ g. # Black staff:_____%_____

h. Breakdown of total staff: i. Breakdown of Black staff:

Administrative:	_____	_____
Medical	_____	_____
Social Service	_____	_____
Nursing	_____	_____
Paramedical	_____	_____
Other	_____	_____

j. Is there much staff turnover? Overall? For Black staff?
(use back of page if necessary)

III. Board of Directors

a. Total # of Board:_____ b. # of Blacks:_____%_____

c. Statuses represented on the Board:

___Businessmen ____Community reps. _____Consumers:_____

___Church parishoners _____Other, specify:_____

IV. What services are provided by the facility?

V. Has resident population changed demographically over the past five years? ____Yes ____No If yes, how? Why?

VI. Sources of referral? How do most residents come to the facility?

VII. Are there differences in how Black clients enter the facility as compared to White residents? If so, specify:

VIII. What is the admission procedure for the facility?
(Who is involved, what discussed, steps in the process)

IX. Are there any special problems for Black families and resident applicants during the admission procedure?

X. Generally, what is the attitude/emotional level of Black families and residents at admission? Different in any way from White admittees?

XI. Funding: Sources of funds, check all which apply:

_____Medicaid, % patients covered:_____ %Blacks _____

_____Medicare, % patients covered:_____ %Blacks_____

_____Social security,% covered :_____ %Blacks_____

_____% Private patients:_____ %Black private ptns:_____

_____Private donations ____Fund-raising, who?_____

Average reimbursement rate:_____

XII. Organizational Structure

Number of departments; departmental arrangements, degree of coordination between different services or departments)

XIII. Administrative Style

a. How would you describe the working relationship between you and your staff:

1. ____very good
____satisfactory
____problematic

2. ____very formal, roles sharply delineated
____professional, but some functions shared across statuses
____ very informal, much sharing of functions, roles not sharply defined
____other, explain:_____
_____

b. When staff have a problem and wish to speak to you, how is it handled? (e.g., door always open, make an appointment; in group staff meetings, etc.)

c. Are patients who have complaints free to see you at anytime?

___Yes____No, If no, how are patient compaints handled?

d. How are complaints by resident's family members handled?

XIV. SANCTION FOR FAMILY INVOLVEMENT

a. How much do you feel family members should be involved in the care of their relatives in this facility?

b. What would you consider too little involvement? Why?

c. What would you consider too much involvement? Why?

e. Are there any differences in the degree of involvement of Black families with their relatives here as compared to other groups?___Yes_____NO If yes, attributable to what?

FACILITY-INITIATED MECHANISMS OF COORDINATION

Listed below are mechanisms which Nursing Homes often use to facilitate a working relationship with the families of residents. Please indicate the degree to which this Home ***.

ACTIVITY	Frequency of Engagement in activity				
	OFTEN	SOMETIMES	ON OCCASION	NEVER	Don't Know
Home takes responsibility for securing information on family member's names, phone and address and updating same					
Home takes responsibility for giving staff important information about family or changes within the family					
Home allocates staff time to work with families and/or assigns staff duty during peak visiting hours					
Assignment of specific staff to work with each family					
Informs family of the name, phone, office hours, etc. of staff members					
Home has covenient and well-publicized visitng hours for family/friends					
Home supports visiting by providing transportation information, coffee shops, lounges, etc.					
Home send correspondence to families about institutional events, important meetings, etc.					
Home has systematic procedures for notification of changes in relative's situation and involvement of family in planning					
Home plans programs for family members to help them understand the aging process, care of the aged, etc.					

FACILITY-INITIATED MECHANISMS OF COORDINATION, cont'd:

ACTIVITY	Frequency of Engagement in Activity				
	OFTEN	SOMETIMES	ON OCCASION	NEVER	Don't Know
Inclusion of family members in celebration of holidays and special events	____	_____	_____	____	_____
Invites family members to join Auxilliary groups, committees, volunteer groups	_____	_____	_____	____	_____
Fund-raising activities among the families of residents, e.g. bake sales, drives, etc.	_____	_____	_____	_____	_____
Home has stated expectations of family involvement	_____	_____	_____	_____	_____
Home reinforces the involvement of families in care of the resident, encourages family input	_____	_____	_____	_____	_____

FOR THE ADMINISTRATOR AND STAFF INTERVIEWS ONLY:

Are there any difficulties in engagement in the above-stated activities with Black families as compared to other families associated with your facility? If so, which activities are problematic and why?

(Administrator Interview) ETHNIC VALUE ORIENTATION

	YES	NO	Is this important to you personally? YES	NO
1. Is the Administrator of the Home Black?	____	____	____	____
2. Are there Blacks among your professional staff?	____	____	____	____
3. Do Black staff participate in program planning?	____	____	____	____
4. Are ethnic foods served on a fairly regular basis to Black residents?	____	____	____	____
5. Is there an effort to include Black cultural content in programs for residents- e.g. music, folklore, arts, etc.	____	____	____	____
6. Are holidays which are important to Black residents celebrated in the Home?	____	____	____	____
7. Are church services held for Black residents which allow worship in the style to which they are accustomed. If not held in the Home are Black residents ever taken to church in the Black community?	____	____	____	____
8. Does the Home seek to sensitize staff to the cultural values and special needs of the Black elderly resident?	____	____	____	____
9. Does your Board of Directors have Black representation?	____	____	____	____
10. Do you support the establishment of separate Black Nursing Homes run and staffed by Blacks for their own aged?	____	____	____	____
11. Does your facility take active steps to involve Black families in the care of their relatives?	____	____	____	____

12. Do you feel it is important for the Home to:

____ treat all people alike regardless of race or cultural background

____ Treat all people well, but recognize differences in ethnic background as it affects patterns of need, preferences re care, food, etc.

____ actively sustain and/or promote pride of residents in their cultural/ethnic backgrounds

13. Are there special needs and problems which Black residents have which are different from those of other residents in this facility? Please explain if answer is yes:

RECORD ANSWER ON BACK OF SHEET

14. What do you feel accounts for the low utilization rate of nursing homes by elderly Blacks. (i.e., lack of need; need for more outreach, etc.):

15. Have you encountered any difficulties in reaching out to Black families re the use of your services? Please explain:

APPENDIX A-1

QUESTIONNAIRE FOR DIRECTOR OF SOCIAL SERVICES

Director's Name:_____

Length of time in current position:_____

Length of time on the facility staff if not same as above:_____

PLEASE ANSWER QUESTIONS ON THE FOLLOWING 4 pp.

Research code no:_____

Facility:_____

FACILITY-INITIATED MECHANISMS OF CO-ORDINATION P.1

Listed below are mechanisms which Nursing Homes often use to facilitate a working relationship with the families of residents. Please indicate the degree to which your facility does these things.

ACTIVITY	Frequency of Engagement in activity				
	OFTEN	SOMETIMES	ON OCCASION	NEVER	Don't Know
Home takes responsibility for securing information on family member's names, phone and address and updating same					
Home takes responsibility for giving staff important information about family or changes within the family					
Home allocates staff time to work with families and/or assigns staff duty during peak visiting hours					
Assignment of specific staff to work with each family					
Informs family of the name, phone, office hours, etc. of staff members					
Home has covenient and well-publicized visitng hours for family/friends					
Home supports visiting by providing transportation information, coffee shops, lounges, etc.					
Home send correspondence to families about institutional events, important meetings, etc.					
Home has systematic procedures for notification of changes in relative's situation and involvement of family in planning					
Home plans programs for family members to help them understand the aging process, care of the aged, etc.					

FACILITY-INITIATED MECHANISMS OF COORDINATION, cont'd:

ACTIVITY	Frequency of Engagement in Activity				
	OFTEN	SOMETIMES	ON OCCASION	NEVER	Don't Know
Inclusion of family members in celebration of holidays and special events	____	____	____	____	____
Invites family members to join Auxilliary groups, committees, volunteer groups	____	____	____	____	____
Fund-raising activities among the families of residents, e.g. bake sales, drives, etc.	____	____	____	____	____
Home has stated expectations of family involvement	____	____	____	____	____
Home reinforces the involvement of families in care of the resident, encourages family input	____	____	____	____	____

FOR THE ADMINISTRATOR AND STAFF INTERVIEWS ONLY:

Are there any difficulties in engagement in the above-stated activities with Black families as compared to other families associated with your facility? If so, which activities are problematic and why?

ETHNIC VALUE ORIENTATION

Staff Interview

	YES	NO	In your view does this Home do these things: YES	NO
1. Is it important to you that the Home's administrator be Black? Would you prefer this?	____	____	____	____
2. Is it important to you to have Black people on the professional staff of the Home? reasons given for answer_____	____	____	____	____
3. Is it important for Black staff to participate in planning programs within the Home?	____	____	____	____
4. Should the Home make an effort to include Black cultural content in programs for residents, e.g., music, folklore, arts, etc.	____	____	____	____
5. Should ethnic foods which Black residents like or request be served on a fairly regular basis by the Home?	____	____	____	____
6. Should the Home celebrate Holidays which are important to the Black elderly residents?	____	____	____	____
7. Should church services be held for Black residents which allow them to worship in a way which are their accustomed manner? Or should the Home at least provide transportation to churches in the Black community.	____	____	____	____
8. Should the Home sensitize staff to the cultural values and special needs of the Black elderly residents?	____	____	____	____
9. Should the Home's Board of Directors have Black representation?	____	____	____	____
10. Do you support the establishment of separate Black nursing homes run and staffed by Black people for their own elderly?	____	____	____	____
11. Should the Home take active steps to involve Black families in the care of their relatives?	____	____	____	____

12. Do you feel it is important for the Home to:

____ treat all residents alike, regardless of their race or ethnic background

____ treat all residents well, but recognize differences in ethnic background as it affects patterns of need, preferences re food, care, etc.

____ actively sustain and/or promote pride of residents in their cultural/ethnic backgrounds

13. Are there special needs and problems which Black elderly people have in facilities such as this one which are different from those of white residents in such facilities?

14. What do you feel accounts for the low utilization rate of nursing homes by elderly Blacks? (i.e., lack of need; need for more outreach; etc.) USE BACK IF NECESSARY

APPENDIX B

____Resident has family

____Resident has no family

RESIDENT INTERVIEW

Resident's Name:_____Code No:_____

Room no.:_____ Facility:_____

Interviewer:_____ Date of Interview:_____

Format for Interview

Step 1: Where permitted by facility, read record for demographic data, address of responsible relative; other pertinent data on other questions in interview

Step 2: Alert nurses station day before to inform resident that you are coming

Step 3: Read study explanation (next page) and HAVE CONSENT FORM SIGNED

Step 4: Conduct interview by levels, beginning with level A. If resident tires, ask permission to return the next time and complete the interview.

Step 5: Thank resident for his/her time and valuable comments. We are very appreciative.

Step 6: Give Staff Check list for Resident to either the Social Service or Nursing staff as discussed in research procedures for this facility.

Step 7: Send Contact letter to resident's responsible relative

Step 8: Follow-up in 2-3 days with a call to family to arrange an interview

Step 9: ALWAYS keep track of the case on your activity sheets to make sure you know what data for each case is still missing.

Code number:_____

1. Age:_____ 2.SEX:___M___F 3. Admission Date:_____

4. Place of birth:_____

5. Marital status
   - __single
   - __Married
   - __Widowed
   - __Divorced
   - __Separated
   - __Unknown

6. Method of Payment (check all which apply)
   - ___Own funds
   - ___Relatives' funds ,who:_____
   - ___ SSI
   - ___Medicaid
   - ___Medicare
   - ___Social security
   - ___Pension
   - ___Other, please specify_____
   - ___Not ascertainable

7. Religion
   - ___Protestant
   - ___Catholic
   - ___Other,specify_____
   - ___Unknown

8. Previous occupation:_____
9. Spouse's occupation:_____
10. Highest grade completed:_____
11. Previous living arrangements: (with whom did resident live prior to admission to this facility?)
    Check ALL which apply:
    - _____Alone
    - _____Spouse
    - _____ Adult daughter(s)
    - _____ Daughter's spouse
    - _____Adult son(s)
    - _____Son's spouse
    - _____Grandchildren
    - _____Resident's siblings
    - ____Friend(s)
    - ____Paid companion
    - ____Other, please specify_____

11a. IF NOT IN PRIVATE HOME:
   - _____Senior Citizens hotel
   - _____Other hotel
   - _____Boarding Home
   - _____Proprietary nursing home
   - _____General Hospital
   - _____Mental Hospital
   - _____Rehabilitation Center
   - ____Other long term care facility
   - ____Other, specify_____

11b. IF ALONE, was there a relative/friend in same building:
   - ___Yes ____No
   - ___Not ascertainable

LEVEL A

RESIDENT SATISFACTION WITH INSTITUTIONAL ARRANGEMENTS

Listed below are 10 areas that I would like for you to evaluate about this facility and the care it provides for you.

AREA EVALUATED	Level of Satisfaction: Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
1. physical surroundings (rooms, lounges)				
2. Medical and nursing care				
3. Food				
4. Social activities				
5. Financial arrangements				
6. Emotional support/ counseling				
7. Attitude of staff/showing of concern				
8. Family involvement with the Facility				
9. Other residents (friendliness, similarity to self, etc.				
10. Accessibility to staff and administrator				

MORALE OF RESIDENT (Resident Interview this will be a self-evaluation)
(Family interview: family member will evaluate resident's morale)

11. Overall, I am:

_____very happy
_____fairly happy
_____not too happy
_____ not happy at all

Why does resident feel this way? _____

_____

LEVEL B

Resident Interview Ethnic Value Orientation Scale

(READ EACH STATEMENT BELOW TO RESIDENT) **Please write on the back reasons residents volunteer for their answers.	Important to Resident		In resident's view does the Home do this:	
	Yes	No	Yes	No
1. Is it important that the Administrator of the Home be Black/Negro/Colored?	____	____	____	____
2. Is it important to have Black/Negro people as doctors, nurses, and social workers in the Home?	____	____	____	____
3. Is it important for Black/Negro staff to participate in planning programs in the Home?	____	____	____	____
4. Should the Home try to include Black culture in its activities like gospel/West Indian music, jazz, dances, folklore, etc.	____	____	____	____
5. Should the home serve ethnic foods like greens, yams, grits, peas and rice, etc.	____	____	____	____
6. Should the Home celebrate holidays which are important to you?	____	____	____	____
7. Should the Home have church services which allow you to worship as you are used to worshiping?	____	____	____	____
8. Should the Home make arrangements to take you to the Church of your choice?	____	____	____	____
9. Should the staff here be taught about the culture and values of the Black elderly?	____	____	____	____
10. Should the Board of Directors of the Home have some Black people on it?	____	____	____	____
11. Do you support the establishment of Nursing Homes run by Black people for their own aged?	____	____	____	____
12. Should the Home take steps to involve Black families in the care of their elderly people?	____	____	____	____

13. Which of the following statements best expresses how you feel:

____the Home should treat all residents alike regardless of their race

____the Home should treat all residents well, but should recognize that people have different values and like different things

____the Home should actively sustain or promote the resident's sense of pride in his culture and his race

LEVEL B, cont'd

14. Are there special problems which you have because you are old?

15. Are there special problems which you have because you are Black/Negro/Colored?

(where applicable ask):

16. How do you get along with the white residents here?

LEVEL C

HAVIGHURST LIFE SATISFACTION SCALE: RESIDENT MORALE

Here are some statements about life in general that people sometimes make. As I read each statement, please tell me whether you agree or disagree with it. If you are not sure how you feel about it, just tell me you're not sure.

Let's start with:	Agree	Disagree	Not Sure
1. As I grow older, things seem better than I thought they would be	____	_____	_____
2. I have gotten more of the breaks in life than most people I know	____	_____	_____
3. This is the dreariest time of my life. . .	____	_____	_____
4. I am just as happy as when I was younger. . .	____	_____	_____
5. Most of the things I do now are boring and all the same	____	_____	_____
6. As I look back on my life, I am fairly well satisfied	____	_____	_____

Level C, cont'd

	Agree	Disagree	Not Sure
7. I have made plans for things I will be doing a month or a year from now.	____	_____	_____
8. When I think back over my life, I didn't get most of the important things I wanted . . .	____	_____	_____
9. Compared to other people, I get down in the dumps too often	____	_____	_____
10. I've gotten pretty much what I expected out of life	____	_____	_____

11. In general would you describe your health as:

_____good

_____fair

_____poor

INTERVIEWER: Write below notes on any observations you have made concerning the resident's morale.

6. Do you feel that this facility and its staff encourage your family members to visit you?_____Yes_____No. Why do you say this?

_____

_____

_____

7. When your family members visit you, do they do any of these things for you when they visit? For example do they:(READ LIST TO RESIDENT)

YES NO

_____ _____give you personal care(bathing, grooming, etc.)Who:_____

_____ _____shopping for you;run errands Who:_____

_____ _____take you on trips or visits with other family members Who:_____

_____ _____help you get to the clinic, doctors outside of the Home Who:_____

_____ _____read to you, play games with you;Who:_____

_____ _____sew for you, help mend your clothes; Who:_____

_____ _____speak to staff on your behalf about problems you have

_____ _____food treats, ethnic foods, fruits(Note examples given)

_____ _____bring you gifts of money; who:_____

_____ _____bring you gifts of clothing; Who:_____

_____ _____bring you plants or things to decorate your room; Who:_____

_____ _____take you to church services; Who:_____

_____ _____bring you books, newspapers, magazines; Who:_____

8. If your family cannot visit as often as they'd like, do they call you on the phone?_____Yes_____No; Who calls:_____

9. Do your family members write letters or send cards?____Yes____No Who:_____

10. Do any of your family members participate in activities sponsored by the Home. For example do they:(READ LIST AND CHECK IF YES)

_____participate as a volunteer in the home; Who:_____

_____help in fund raising; Who:_____

_____donate money to the Home; Who:_____

_____come to programs given by the Home for families;Who:_____

_____other things mentioned, please specify:

_____Who:_____

_____Who:_____

LEVEL D p.7

PATTERNS OF VISITING AND CURRENT INTERACTION WITH FAMILY MEMBERS

1. Could you give me some idea of who visits you within your family and how often they visit. For instance, does your:

Relationship of member to resident	Pattern of Visiting: Daily	Weekly	Monthly	Few times a year	Yearly	Never	Not Applicable
Your spouse							
Daughter(s)							
Son(s)							
Grandchild(ren)							
Sister(s)							
Brother(s)							
Cousin(s)							
Others in family(specify who)							

2. Do any of your close friends visit you here?____Yes_____No
If yes, specify who and how often:

3. Do volunteers here in the Home visit with you?____Yes_____No
How often?

4. Is there anyone in particular in your family that you would like to see more often?____Yes____No. If yes, who:

5. Are there problems which make it difficult for your family to visit with you?_____Yes_____No . If yes, what are they?:

LEVEL D for Family-Loss Residents p.9

1. Do you get visits from people who live outside of the nursing home? ____Yes ____No

For example, do you get visits from? (READ LIST)	How often do they come to see you?: Daily	Weekly	Monthly	Yearly	Never	N.A.
• one or two special friends						
• many friends						
• former neighbors						
• members of the church (if not listed above)						
• volunteers in the Home						
• others, please specify:						

2. What kinds of things do your visitors do for you and with you when the come to visit? For example do they: (READ LIST)

	YES	NO	If yes, specify who:
• help you bathe, dress, brush hair			
• shopping or running errands			
• take you on trips			
• help you get to the clinic/doctor			
• read to you, play games with you			
• sew for you, mend your clothes			
• speak to staff on your behalf about problems you are having			
• give you spending money			
• bring you food treats(note examples)			
• bring you clothes			
• bring you plants, room decorations			
• take you to church services			
• bring you books, newspapers, etc.			

3. If your friends cannot visit do they call you on the phone?___Yes____No
and calls and how often? _____

4. Do your friends send you cards and letters?_____Yes_____No,Who:_____

5. Would like to have more visitors? ___Yes_____No. If yes, anyone special?:

LEVEL E p.10

PAST PATTERNS OF INTERACTION WITH FAMILY/FRIENDS/NEIGHBORS

READ: As you know , parents and children and sometimes friends and neighbors help each other out in many different ways. Before you came to live here, what did you do to help out your children or friends?:

INTERVIEWER READ LIST: Frequency key: O=often S=sometimes N=never (circle)

1. Resident did for:	FOR MY CHILDREN			FOR MY FRIENDS			FOR MY NEIGHBORS		
• help when they were sick	O	S	N	O	S	N	O	S	N
• babysit	O	S	N	O	S	N	O	S	N
• give advice on running the house or childcare	O	S	N	O	S	N	O	S	N
• shop or run errands	O	S	N	O	S	N	O	S	N
• give gifts	O	S	N	O	S	N	O	S	N
• help them out with money	O	S	N	O	S	N	O	S	N
• fix things in their house	O	S	N	O	S	N	O	S	N
• give advice on job and business matters	O	S	N	O	S	N	O	S	N
• help them make big decisions like buying a car or house	O	S	N	O	S	N	O	S	N
• keep house for them	O	S	N	O	S	N	O	S	N

2. They did for resident:	DONE BY CHILDREN			DONE BY FRIENDS			DONE BY NEIGHBORS		
• help you when you were ill	O	S	N	O	S	N	O	S	N
• give you advice on money matters	O	S	N	O	S	N	O	S	N
• help you make big decision	O	S	N	O	S	N	O	S	N
• shop or do errands for you	O	S	N	O	S	N	O	S	N
• give you gifts	O	S	N	O	S	N	O	S	N
• help fix things in your house/apartment	O	S	N	O	S	N	O	S	N
• keep house for you	O	S	N	O	S	N	O	S	N
• cook for you,but not keep house for you	O	S	N	O	S	N	O	S	N
• take you on trips	O	S	N	O	S	N	O	S	N
• help you out with money	O	S	N	O	S	N	O	S	N
• drive you places such as doctor/shopping/church	O	S	N	O	S	N	O	S	N
• Just socialize, visit have fun together	O	S	N	O	S	N	O	S	N

3. How would you describe the relationship between you and your family?

___Very close ____somewhat close ____not too close _____not close at all

LEVEL F

DECISION MAKING PROCESS AROUND ADMISSION OF RESIDENT TO THE HOME

1. Did anyone help you in making the decision to come to live here?

Who (List each)	Relationship to resident	How did they help you decide:

(Use back of page if additional space is required)

2. What were the major reasons for entry to the facility? (Check all which apply or are mentioned):

_____couldn't manage alone
_____fear of living alone
_____loneliness
_____changing neighborhood
_____loss of home/apartment
_____death of spouse
_____financial need
____poor physical health
____loss of mobility
____mental disorientation
____fear of declining health
____family unable to continue care
____other, please specify below:
_____

3. Who referred you to this facility?_____

4. Was there something you liked about this facility in particular?
If so, what:_____

_____

5. Did you consider alternatives to a residential care facility?
____Yes, what were they:_____

____NO

6. Did you visit other nursing homes?_____Yes _____No , Number visited:_____

7. How did you feel about. . . the decision to come here? (Answer below):

_____

_____

8. Do you feel you made the right decision? ___Yes ____No___Uncertain
Reason for your answer:

_____

_____

APPENDIX C

FAMILY INTERVIEW

Resident's Name:_____Code No:_____

Name of Family Member
being Interviewed:_____

Relationship to Resident:_____ Date of Interview:_____

How interviewed:_____In Person _____Telephone

Name of Interviewer:_____

- READ EXPLANATION OF STUDY (NEXT PAGE), ENTERTAIN QUESTIONS IF ANY
- Have family member SIGN CONSENT FORM
- Use space below for your observations with respect to any of the data collected in this interview. Note question number.

INTERVIEWER OBSERVATIONS

Code No.:_____
(Family Interview)

DEMOGRAPHIC DATA SHEET ON RESIDENT'S FAMILY

Family Composition

1. Number of surviving children:
   a. Number of daughters_____ b. Number of sons:_____
   c. Number of children, sex not ascertainable:_____
   d. ____No children e:____not ascertainable

2. FOR EACH surviving child: list his/her sex, age, place of residence:

Sex	Age	Has own children	Place of Residence
___	____	___Yes ____No	_____
___	____	___Yes ____No	_____
___	____	___Yes ____No	_____
___	____	___Yes ____No	_____

(Use back of sheet if additional listing space is required)

3. Are there great grandchildren?_____Yes_____No Number:_____

4. Number of surviving SIBLINGS OF RESIDENT:
   ____Number of sisters _____Number of brothers
   ____ There are siblings, but number is unknown ____Not ascertainable

5. FOR EACH surviving SIBLING OF RESIDENT list, age, sex, marital status, whether children, where residing:

Age	Sex	Married	Own Children	Where currently residing
___	___	__Y __N	___Yes___No	_____
___	___	__Y __N	___Yes___No	_____
___	___	__Y __N	___Yes___No	_____

(Use back of sheet if additional space is required)

6. Are there deceased children of resident?____Yes ____No ____Number

7. Are there deceased siblings of resident?____Yes ____No ____Number

8. Are there grandchildren of resident near the facility?
   ___Yes, who and where do they live? (answer below) ____NO

Demographic data sheet on family - 2 -

Significant Others

9. Are there close friends of the resident near the facility?
____Yes, who and where do they live? (answer below) _____No

10. Who is listed as the key relative on admissions form:

Who:_____Relationship_____

11. If no key relative, who else as listed as contact person in case of emergency? Who:_____Relationship_____

12. DATA ON RESPONDENT FOR THE FAMILY INTERVIEW

Family member's age:_____(a) Sex_____(b)

c) highest educational level attained:_____

d) Income range: _____under $5,000
(annual family income) _____$5,000-$10,000
_____$10,001- $15,000
_____$15,001- $20,000
_____$20,001 and over

e) current occupation of family member:_____

f) spouse's occupation, if married:_____

13. DATA ON OTHER CHILDREN OF THE RESPONDENT: List for each identified:

Education Level(highest)	Occupation currently held	Makes a financial contribution to the resident's care at facility
_____	_____	_____YES_____NO
_____	_____	_____YES_____NO
_____	_____	_____YES_____NO
_____	_____	_____YES_____NO
_____	_____	_____YES_____NO

(Use back of sheet if more space is required)

DECISION MAKING PROCESS AROUND ADMISSION OF RESIDENT TO THE HOME

14. Who was involved in the decision to seek admission to the facility? LIST EACH PERSON MENTIONED: (include professionals)

Who (List each)	Relationship to resident	Role played in the decision making

(Use back of page if additional space is required)

15. What were the major reasons for entry to the facility? (Check all which apply or are mentioned):

_____couldn't manage alone
_____fear of living alone
_____loneliness
_____changing neighborhood
_____loss of home/apartment
_____death of spouse
_____financial need
____poor physical health
____loss of mobility
____mental disorientation
____fear of declining health
____family unable to continue care
____other, please specify below:
_____

16. Who referred you to this facility?_____

17. Was there something you liked about this facility in particular?
If so, what:_____
_____

18. Did you consider alternatives to a residential care facility?
____Yes, what were they:_____
____NO

19. Did you visit other nursing homes?_____Yes _____No , Number visited:_____

20. Did your___/_____visit with you?_____Yes _____No
(refer to resident)

21. How did your_____accept the decision to come here? (Answer below):
_____
_____

22. Do you feel you made the right decision? ___Yes ____No___Uncertain
Reason for your answer:
_____
_____

PAST PATTERNS OF INTERACTION WITH RESIDENT

23. Before your ____came to live here, how often did you see him/her?
__daily __weekly ____bi-weekly ___monthly ___ every few months
__yearly or less ____not ascertainable

24. Would you say this is also true for most members of your family?
___Yes ____No. If not, did others visit ____more____same_____less?

25. Do you think that your____would like to have seen more of the family? _____Yes _____No _____Don't know.

26. READ: As you know parents and children often help each other out. Before your ____came to live here did she/he do any of these things to help you out (READ LIST): O=often S=Sometimes N=never

Type of help offered:	How often for you?			Other family? WHO:
• help/care when sick	O	S	N	_____
• babysit with grandchildren	O	S	N	_____
• give advice on home/child care	O	S	N	_____
• shop or run errands	O	S	N	_____
• give gifts	O	S	N	_____
• help out with money/loans	O	S	N	_____
• fix things around your house	O	S	N	_____
• give advice on job/business matters	O	S	N	_____
• help make big decisions	O	S	N	_____
• keep house	O	S	N	_____

27. What kinds of things did you do to help your___out? For example: (Read)

Type of help offered:	How often by you			By other family: WHO
• help/care when ill	O	S	N	_____
• advice to parent on money matters	O	S	N	_____
• help making big decisions	O	S	N	_____
• shopping/ running errands	O	S	N	_____
• giving gifts to resident	O	S	N	_____
• fixing things in resident's home	O	S	N	_____
• keeping house for resident	O	S	N	_____
• cooking for, but not keeping house	O	S	N	_____
• take resident on trips/vacations	O	S	N	_____
• help resident with money/loans	O	S	N	_____
• take resident to church, doctor, etc.	O	S	N	_____
• just socialize, visit, have fun	O	S	N	_____

28. How would you describe your relationship with your_____?
___very close ____somewhat close ____not too close ___not close at all

(Family Interview)
p.5

PATTERNS OF VISITING

29. How often do you visit your_____now?

____Daily
____several times a week
____weekly
___Not acertainable
____several times a month
____monthly
____every few months
____once or twice a year
____yearly or less

30. What about other family members? Do they visit____More than you do, _____less than you do, ____or about the same?

31. Could you give me some idea of who visits your_____and how often? Listed below are categories of family members. Think about your family and tell me how often these members visit your_____, if you know:

Relationship	Pattern of Visiting: Daily	Weekly	Monthly	Few times a year	Yearly	Don't know	N.A.
Resident's spouse	____	____	____	_____	____	____	____
My brothers & sisters	____	____	____	_____	____	____	____
Resident's grandchildren	____	____	____	_____	____	____	____
Resident's siblings	____	____	____	_____	____	____	____
Resident's cousins	____	____	____	_____	____	____	____
Resident's closest friend(s)	____	____	____	_____	____	____	____
Former or current church members	____	____	____	_____	____	____	____
Other specify: _____	____	____	____	_____	____	____	____

32. Do you wish you could visit more often? ____Yes _____NO

33. If yes in #32, are there problems which make visiting difficult?
What are they:_____
_____(Use back if needed)

Patterns of visiting , cont'd. p.6

34. Do you feel that this facility and its staff encourage family members to visit?____Yes _____No. Why do you say this?

35. When you visit with your relative do you do any of these things for him/her or with him/her? For example do you or other members of your family: (READ LIST)

Activity	Respondent Does			Anyone else? WHO:
• grooming, bathing, feeding	O	S	N	_____
• shopping, run errands	O	S	N	_____
• take resident on trips, to visit other family members	O	S	N	_____
• take resident to doctor/clinic	O	S	N	_____
• reading, playing games	O	S	N	_____
• sewing/mending clothes	O	S	N	_____
• have conferences with administrat. or staff re problems/ poor treatment of the resident	O	S	N	_____
• bring gifts of money	O	S	N	_____
• bring gifts of clothing/jewelry	O	S	N	_____
• bring special food treats (note examples on back of page)	O	S	N	_____
• take relative to church	O	S	N	_____
• bring papers, books, magazines	O	S	N	_____

36. If you cannot visit, do you call?____Yes____No. How often?_____

_____

37. Do you write or send cards? ____Yes _____No.How often?_____

38. Do you or other family members engage in any of the following activities for the nursing home? For example (READ LIST):

Activity	Respondent Does			Anyone Else?WHO:
• Volunteer in the Home	O	S	N	_____
• Fund raising	O	S	N	_____
• Donate money	O	S	N	_____
• Attend special programs for family	O	S	N	_____
• Relative's Council	O	S	N	_____
• Other, please specify:	O	S	N	_____

_____

_____

39. Do you feel comfortable in contacts with staff?___Yes ____No

(40) NOTE REASONS ON BACK OF PAGE

Degree of involvement, social distance

41. Do you feel that the administrator and staff respect you and your values, wishes, etc? ____Yes _____No

Reasons for answer:

_____

_____

_____

42. Do you feel that your _____is comfortable here?

____Yes _____No _____Don't know/Reason for answer:_____

_____

_____

43. Are there staff members you can take your problems to and feel that they will help you? _____Yes _____No

Who:_____

44. Do you ever join with other families of residents to work on special projects or special problems related to care of your relatives? ____Yes _____No

What have you done for example:_____

_____

Below are some attitude items. I would like for you to express the way you feel about each of the statements below:

45. I often visit my relative even though I don't really want to. ___true ____not sure _____not true

46. I feel guilt when I think of ____in a nursing home. ___true ____not sure ____not true

47. I often feel that I should not have put___in a Home. ___ ___not sure ____not true

48. I am often ashamed to tell people that my___is in a nursing home. ___true ___not sure ____not true

49. If I had it to do over again I would try an alternative to a nursing home. ___true ___not sure ___not true

50. Do you feel it is important for family members to be involved with the care of their relatives who are in nursing homes? ____Yes ___No ____Can't say. Reasons for answer:_____

_____

(use back of page if more space is required)

FAMILY-INITIATED MECHANISMS OF COORDINATION

Listed below are mechanisms which families of residents often use to facilitate a working relationship with the Home or to influence the staff. Please indicate the degree to which **_____'s family has done any of these things:

ACTIVITY	Frequency of engagement in activity				
	OFTEN	SOMETIMES	OCCASIONALLY	NEVER	Don't Know
Family took responsibility for giving Home names, addresses and phone numbers of family members or changes in each	____	____	____	____	____
Family getting to know staff by name and position and seeking contact during visits	____	____	____	____	____
Family initiating conferences with staff re relative's situation	____	____	____	____	____
Family gives gifts or tips to staff	____	____	____	____	____
Financial or in-kind services to the Home	____	____	____	____	____
Volunteer services to the Home	____	____	____	____	____
Attends programs for families planned by the Home	____	____	____	____	____
Membership in Auxilliary organizations of the Home	____	____	____	____	____
Letters of appreciation to the Home/staff	____	____	____	____	____
Referral of potential applicants to the Home	____	____	____	____	____
Complaints to the administrator, Board, or supervisors re unsatisfactory treatment of relative/self	____	____	____	____	____
Complaints to government officials, influential persons, or mass media re unsatisfactory treatment	____	____	____	____	____
Joining organizations(e.g. FRIA) to bring about change of conditions in the Home	____	____	____	____	____

(Resident Interview) p.9

(Family Interview)

EVALUATION OF SERVICES AND RESIDENT MORALE

Listed below are 10 areas that I would like for you to evaluate about this facility and the care it provides to your relative:

	Level of Satisfaction			
AREA EVALUATED	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
1. physical surroundings (rooms, lounges)				
2. Medical and nursing care				
3. Food				
4. Social activities				
5. Financial arrangements				
6. Emotional support/ counseling				
7. Attitude of staff/showing of concern				
8. Family involvement with the Facility				
9. Other residents (friendliness, similarity to self, etc.				
10. Accessibility to staff and adminstrator				

MORALE OF RESIDENT (Resident Interview this will be a self-evaluation)
(Family interview: family member will evaluate resident's morale)

11. I feel that my relative is: _____ very happy
_____ fairly happy
_____ not too happy
____ not happy at all

Reasons for this evaluation: _____

(Family Interview) Staff Interview — ETHNIC VALUE ORIENTATION

	YES	NO	In your view does this Home do these things: YES	NO
1. Is it important to you that the Home's administrator be Black? Would you prefer this?	____	____	____	____
2. Is it important to you to have Black people on the professional staff of the Home? (Note spontaneous reasons given for answer_____	____	____	____	____
3. Is it important for Black staff to participate in planning programs within the Home?	____	____	____	____
4. Should the Home make an effort to include Black cultural content in programs for residents- e.g., music, folklore, arts, etc.	____	____	____	____
5. Should ethnic foods which Black residents like or request be served on a fairly regular basis by the Home?	____	____	____	____
6. Should the Home celebrate Holidays which are important to the Black elderly residents?	____	____	____	____
7. Should church services be held for Black residents which allow them to worship in ways which are their accustomed manner? Or should the Home at least provide transportation to churches in the Black community.	____	____	____	____
8. Should the Home sensitize staff to the cultural values and special needs of the Black elderly residents?	____	____	____	____
9. Should the Home's Board of Directors have Black representation?	____	____	____	____
10. Do you support the establishment of separate Black nursing homes run and staffed by Black people for their own elderly?	____	____	____	____
11. Should the Home take active steps to involve Black families in the care of their relatives?	____	____	____	____

12. Do you feel it is important for the Home to:

_____ treat all residents alike, regardless of their race or ethnic background

_____ treat all residents well, but recognize differences in ethnic background as it affects patterns of need, preferences re food, care, etc.

_____ actively sustain and/or promote pride of residents in their cultural/ethnic backgrounds

ETHNIC VALUE ORIENTATION (2)

13. Are there special needs and problems which Black elderly people in facilities such as this one have which are different from those of white residents in such facilities?

SOCIAL SERVICE/NURSING STAFF CHECKLIST FOR RESIDENT

Code No.:_____

This form completed by:_____Position:_____

_____Position:_____

1. What were the major reasons for resident's entry to the facility? (Check all which apply):

____couldn't manage alone
____fear of living alone
____fear of getting sick without care
____loneliness
____changing neighborhood
____loss of home/apartment
____death of spouse
____poor physical health
____loss of mobility
____mental confusion
____family unable to continue care
____financial need
____other reasons, please state:
_____
_____

2. Who referred the resident to this facility?_____

3. Were other care arrangements considered?____Yes ___No ____Don't Know

4. In your opinion, how did the family accept the decision to have their relative come live here?

5. In your opinion, how did the resident accept the decision to come live here?

6. Has the resident's family ever expressed doubts about this decision?
____Yes ____No ___Don't Know. If yes, what have they said:

7. In general, how would you rate this resident's morale?

____very happy
____fairly happy
____not too happy
____not happy at all

8. Listed below are several members of the family. Please think about this resident's family and tell me how often each of these family members visits him or her. In the last two instances, please answer for the resident's friends.

	Daily	Weekly	Monthly	Every few Months	Yearly	Don't Know	Resident doesn't have any
Resident's spouse							
Resident's daughter(s)							
Resident's son(s)							
Resident's grandchildren							
Resident's sister(s)							
Resident's brother(s)							
Other relatives							
Resident's friend(s)							
Visitors from Church							
Other, who?							

9. Do you know of any difficulties which make it difficult for family members to visit? ____Yes____No ____Don't Know. If yes, what:

10. If relatives cannot visit, do they call ?____Yes____No____Don't Know

11. Do relatives send cards and letters? ____Yes____No____Don't Know

12. Do you think relatives of this resident are comfortable in their relationships with the staff? ____Yes ___No____Don't Know. If no, why?

13. Does the family feel free to come to you or other staff when they have complaints? ___Yes____No____Don't Know

Code No.:_____

STAFF CHECKLIST FOR RESIDENT HEALTH STATUS

14. Functional Health Status of the Resident (To be completed by medical or social service staff)
Listed below are areas of physical, emotional and social functioning. Please evaluate each for this resident.

Physical	Excellent	Good	Fair	Poor	Cannot Evaluate
General health					
Eyesight					
Hearing					
Speech					
Appetite					
Sleeping					
Feeding self					
Toileting					
Dressing					
Grooming					
Ambulation					
Emotional/Mental					
Awareness of surroundings					
Sociability with others					
Participation in activites					
Control of emotions					
Self-esteem					
General morale					
Judgment					
Recall					

APPENDIX E

INFORMED CONSENT FORMS

E 1: Oral explanation to Residents

E 2: Resident Consent Form

E 3: Oral/written explanation to Family Member

E 4: Family Consent Form

STATEMENT OF EXPLANATION

(To be read aloud to each subject participating in the study)

We are required by New York State and Federal Law to provide you with an explanation of this study and what we hope to gain from it. We will also give you the opportunity to ask any questions about the study and your participation in it before the interview begins. If you agree to be interviewed, the law also requires that you sign a Consent Form indicating that the purpose of the study has been explained to you and that you have been told that you may refuse the interview or stop the interview once it has begun if you wish to do so.

STATEMENT OF PURPOSE

There has been very little research done on elderly Black people who live in nursing homes. We are interested in knowing something about you; if you have any special needs or problems as a resident in this nursing home; how satisfied you are with your care, and something about your decision to come here to live. We are also interested in your involvement with your family before you came to the Home and since you have been here. It is our hope that this information can help us to express the needs of elderly Black people to the larger community, particularly people in a position to change policy and programs to enhance the quality of life for older people.

All of your answers will remain strictly confidential. When the report of the study is written, your name will not be used. You have the right to refuse to be interviewed for this study. You may also stop the interview at any point once it has begun if you wish. Needless to say, we would be very grateful if you do agree to be part of the study. Please feel free to ask any questions you may have about the study or your participation in it. (ALLOW TIME HERE FOR QUESTIONS. IF REPONDENT AGREES TO BE INTERVIEWED, HAVE HIM/HER SIGN THE CONSENT FORM AND PROCEED WITH THE INTERVIEW).

Project Title: "Factors Influencing the Cooperation Between Black Families and Nursing Homes in the Care of the Institutionalized Black Elderly"

Principal Investigator: Barbara Jones Morrison
Doctoral Candidate
Columbia University School of Social Work

RESIDENT CONSENT FORM

I, the undersigned, am participating in this research project of my own free will. The purpose of the study and the potential benefits sought have been explained to me. I have been given ample time to ask questions about the study and my role in it, including possible risks to me because of my participation.

I understand that I have the right to refuse the 1-hour study interview or to withdraw from the interview at anytime during the course of the interview. I have been told that I will not be penalized in any way in the event that I choose to refuse the interview.

I understand that my answers to the study questions will be kept confidential and that my name will not be used in any of the research findings or reports.

Respondent's Name: _____
(Please print)

X _____
(Respondent's SIGNATURE)

_____
(*) (Signature of Auditor-Witness)

Date: _____

(*) Have floor nurse, social worker or other staff witness the "signature" of people who are illiterate and can only make the "X" or where the subject is physically unable to write his/her name and must make an "X" to express his consent.

For the Family Interview IF DONE IN PERSON RATHER THAN TELEPHONE

STATEMENT OF EXPLANATION

(To be read to each subject participating in the study)

We are required by New York State and Federal Law to provide you with an explanation of this study and what we hope to gain from it. We will also give you the opportunity to ask any questions you may have about the study or your participation in it. If you agree to be interviewed, the law also requires that you sign a CONSENT FORM indicating that the purpose of the study has been explained to you and that you have been told that you may refuse the interview or stop the interview once it has begun if you so desire.

STATEMENT OF STUDY PURPOSE

There has been very little research done on the special needs and problems of elderly Black people who require institutional services and their families. We would like to gain more insight into this area and that is the main purpose of this study. We are interested in knowing something about your elderly relative, if he or she has any special needs or problems as a resident of a nursing home; how satisfied you and your relative are with the level of care being provided, and some information on the decision to have your relative come to live at the nursing home. In addition, we are interested in your relationship with your elderly relative. It is our hope to begin to fill the gap in knowledge about elderly Black people and to make known any special needs which they are expressing. By making this information available to the larger public and professionals in the field of aging, we hope to enhance the quality of life for all of our older people.

All of your answers will remain strictly confidential. We will not use your name or your relative's name in any of the study reports. You may refuse the interview or stop it at any point once it has begun. Needless to say, we would be most grateful for your cooperation with the study. Please feel free now to ask any questions you have. (ALLOW TIME FOR QUESTIONS. IF SUBJECT AGREES, HAVE CONSENT FORM SIGNED AND PROCEED WITH INTERVIEW).

Project Title: "Factors Influencing the Cooperation Between Black Families and Nursing Homes in the Care of the Institutionalized Black Elderly"

Principal Investigator: Barbara Jones Morrison
Doctoral Candidate
Columbia University School of Social Work

FAMILY MEMBER CONSENT FORM

I, the undersigned, am participating in this research project of my owm free will. The purpose of the study and the benefits hope to be gained from it have been explained to me. I have been given time to ask questions about the study and my role in it, including possible risks to me because of my participation in it.

I understand that I have the right to refuse the interview or to withdraw from the interview at anytime during the course of the interview. I have been told that I will not be penalized in any way in the event that I refuse the interview.

I understand that my answers to all questions will be kept confidential and that my name will not be used in any of the research findings or reports.

Respondent's Name:_____
(Please print)

X_____
Respondent's Signature

Date:_____

APPENDIX F

FORM LETTERS TO STUDY RESPONDENTS

(F1)

Hunter College

OF THE CITY UNIVERSITY OF NEW YORK ; SCHOOL OF SOCIAL WOPK 129 EAST 79 STREET, NEW YORK, N.Y. 10021

(212) 570-5037

LETTER TO FACILITY ADMINISTRATORS

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.
.
.

Dear

I am contacting you at the suggestion of the field staff at the New York City Department on Aging. I am a member of the faculty of the Hunter College School of Social Work and a doctoral candidate at the Columbia University School of Social Work.

I am planning to do my dissertation on elderly Blacks in nursing homes in New York City. I am especially interested in interviewing residents who have families available, but would like to also interview a few residents who are without families.

Your facility was suggested to me as one which served Black clients and I am writing to ask your permission to interview some or all of your Black residents, as well as some of their family members.

Attached is a prospectus of the study which will provide you with a better understanding of what the study is about and what your participation in it would entail. I would be grateful for the opportunity to meet with you and any of your staff or Board whom you feel would like some personal clarification from me on the study or any aspects of its implementation.

I look forward to hearing from you at your opportunity.

Sincerely Yours,

Barbara J. Morrison

Barbara J. Morrison,M.S.W.
Asst. Professor
Hunter College
School of Social Work

(F2)

Hunter College

OF THE CITY UNIVERSITY OF NEW YORK ; SCHOOL OF SOCIAL WORK 129 EAST 79 STREET, NEW YORK, N.Y. 10021

STUDY TOPIC: Factors Influencing the Cooperation Between Black Families and Nursing Homes in the Care of the Institutionalized Black Elderly

DATA TO BE COLLECTED: Semi-structured interviews with the facility Administrator, selected Black residents and one of their family members will be undertaken. In addition a short 3pp. checklist to be completed by nursing and/or social service staff evaluating the functional health status of the resident will be requested. Collectively, these data will provide information on the following areas:

FACILITY-RELATED	RESIDENT-RELATED	FAMILY-RELATED
Auspice and History	Demographic Characteristics	Nature of Family Network
Organizational Structure	Functional health Status	Demographic characteristics
Working relationship with Families of residents	Attitudinal data	Patterns of visiting with resident
Services Offered	Decision-making re entry to the Home	Role in decision-making to enter facility
	Morale	Satisfaction with care arrangements
	Satisfaction with care arrangements	

All data will be confidential. The identity of residents, family members, and staff will not be revealed in any of the study findings or reports. Where requested, participating facilities will also remain anonymous.

WHO WILL DO THE INTERVIEWING: As principal investigator, Prof. B. Morrison will do the Administrator Interview. Interviews with residents and family members will be done by B. Morrison and a small cadre of Black M.S.W.'s who are recent graduates of the Hunter College School of Social Work. Each of these individuals has had practice exposure to elderly and aged populations.

HOW LONG WILL INTERVIEWS BE: It is anticipated that the Administrator interview will take one hour. Based on pre-test results, the resident and family member interviews are between 45 mins. and an hour. The staff checklist is given to the nursing and/or social work staff at the beginning of research involvement with the facility and is requested to be returned when the interviewing is completed(usually 3 weeks). Every effort will be made to do interviewing during hours designated by the facility as least disruptive to ordinary routine. Family members will not be contacted for an interview without the consent of residents. Both residents and family members will be asked to sign a consent form as required by State Department of Health Regulations relative to protection of human subjects in research.

SAMPLE: There are ten facilities in the N.Y. City area selected for inclusion in the study because of the number of Black elderly residents in their population. They are all licensed nursing homes or health-related facilities. It is anticipated that approx. 20-25 residents will be interviewed in those facilities which have substantial numbers of Black aged. If the number served is less than 25, all Black aged residents will be selected for inclusion in the study. Where the resident is not able to complete the interview because of mental impairment or physical illness, the family interview will be sought.

HOW WILL THE RESEARCH FINDINGS BE USED: The final research report will constitute a partial fulfillment of requirements for the D.S.W. degree at the Columbia University School of Social Work. The study, however, is seen as much more than a dissertation. There is considerable interest in developing more empirically-based data on the minority elderly. Funds for this area of study are being made available from several sources, the most notable of which is the Administration on Aging (DHEW). A grant to finance the study outlined herein is being requested from AOA. If awarded there is the likelihood the AOA may seek to publish study findings making the data available to gerontologists and practitioners in the field of aging on a national level.

Data obtained in the study will be analyzed, written-up and submitted for publication and dissemination to practitioners, policy-makers and other researchers in the field of aging. The paramount purpose of the study is to shed some light on the life circumstances of a badly neglected segment of our elderly population: elderly Blacks in need of institutional care. It is hoped that the findings of this study will lead to viable recommendations for policy and programmatic activities which will enhance the quality of life for the frailest of the Black aging population. All participating facilities will be given copies of the final study report for their own information and use.

Hunter College

OF THE CITY UNIVERSITY OF NEW YORK | SCHOOL OF SOCIAL WORK | 129 EAST 79 STREET, NEW YORK, N.Y. 10021

LETTER TO SOCIAL SERVICE STAFF

570-5064

Within the next 3-4 weeks, we will be interviewing the Black residents in your social service caseload. The individual who will be interviewing "your"residents will be

I hope that you will not mind if consults with you on occasion about a specific resident. All interviewers have been asked to keep this to a minimum.

Finally, part of the research design calls for completion of a 3pp. checklist per resident in the sample. This list is to be completed by either the nursing staff, social service staff or both : in effect, whoever is in the best position to have the knowledge of the resident required to answer the items. The items address to areas: patterns of visiting by the family (i.e, who and how often) and the physical and mental functional health status of the resident. To the degree that you, as the case social worker, can provide this information on the basis of your familiarity with the resident and his situation, it will be unnecessary for us to review the social service records. With an appreciation of the demands on your time, I am sending these forms to you now and I ask that you complete them as you have time. I would like to have them returned by the time we complete interviewing at which is projected to be the end of I would greatly appreciate your cooperation with this phase of the research.

Please feel free to call me if you have any questions.

Sincerely Yours,

Barbara J. Morrison

Barbara J. Morrison, M.S.W.

(F4)

Hunter College

OF THE CITY UNIVERSITY OF NEW YORK | SCHOOL OF SOCIAL WORK | 129 EAST 79 STREET, NEW YORK, N.Y. 10021

INTERVIEW REQUEST LETTER TO AGED RESIDENTS

I am a member of the faculty of the Hunter College School of Social Work and a doctoral candidate at Columbia University. I am presently doing a study of the relationships between people like yourself, who live in Homes for the Aged and their friends and relatives.

I would be very grateful if you would be willing to talk to me or one of the other study staff members. We will stop by to introduce ourselves to you, and if you agree to be part of the study, we can arrange a date and time for the interview.

We look forward to meeting you.

Sincerely Yours,

Barbara Jones Morrison

Barbara Jones Morrison, M.S.W.
Hunter College
School of Social Work

(F5)

Hunter College

OF THE CITY UNIVERSITY OF NEW YORK | SCHOOL OF SOCIAL WORK | 129 EAST 79 STREET, NEW YORK, N.Y. 10021

INTERVIEW REQUEST LETTER TO FAMILY MEMBERS

570-5064

Dear Relative:

I am a member of the Faculty of the Hunter College School of Social Work and a doctoral candidate at Columbia University. I am presently undertaking a study of the Black aged who live in Nursing Homes and their families. I would be very grateful if you would permit me or one of the study staff to interview you.

The interview takes about ½ hour and could be done at the Nursing Home the next time you visit your relative or over the telephone if you prefer. I will call you within the next few weeks to ask if you are willing to be part of the study, and if so, to arrange a date and time for the interview.

I wish to stress that your answers to the questions will be confidential. It is my hope that this research will be used to help policy-makers and administrative staff in facilities which serve the Black elderly establish funding and service priorities which will enhance the quality of life for our older citizens.

I look forward to your cooperation with this very important research.

Sincerely Yours,

Barbara Jones Morrison

Barbara Jones Morrison, M.S.W.
Research Fellow
Brookdale Center on Aging
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FOLLOW-UP LETTER TO FAMILY REFUSALS

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Dear

Several days ago you were approached by a member of my research study staff for a personal interview as part of the study I am doing of older Black people who live in nursing homes or other long-term care facilities in the N.Y.C. area.

You did not wish to be interviewed and I, of course, respect your right to refuse the interview. I have found, however, that people who do not care for a personal interview are sometimes willing to complete a written questionnaire. Although I would much prefer to speak to you in person, I do not want to lose the valuable information which only you can provide as a family member or close friend. I would be very grateful if you would take a few minutes to complete the enclosed questionnaire. I have enclosed a self-addressed stamped envelope for its return.

I wish to assure you that your answers will be kept confidential and neither your name or identity will be revealed in any of the research findings or reports.

It is my hope to publish the study findings for the use of policy-makers and practitioners in the field of aging. The information which you and your relative can provide will be very valuable in two ways: first, it can serve to sensitize service providers to the special needs and concerns of older Black people and their families; and, secondly, it can indicate ways in which existing services in long-term care facilities can be altered to insure that the frailest of our aged people live their remaining years in the best circumstances possible.

Thank you for your cooperation.

Sincerely Yours,

Barbara J. Morrison

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LETTER OF APPRECIATION TO RESIDENT AND THEIR FAMILY MEMBERS

Thank you so much for permitting us to interview you as part of our study of elderly people in Nursing Homes. I sincerely hope to portray accurately what kind of arrangements older people and their families make for care in the later years. It is my hope that the valuable information you have shared with us will help Homes for the Aged and other long-term care facilities improve the quality of their services to the elderly and their families.

I very much appreciate your taking the time to talk about your thoughts and experiences.

Sincerely Yours,

Barbara Jones Morrison

Barbara Jones Morrison, M.S.W.
Hunter College
School of Social Work

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